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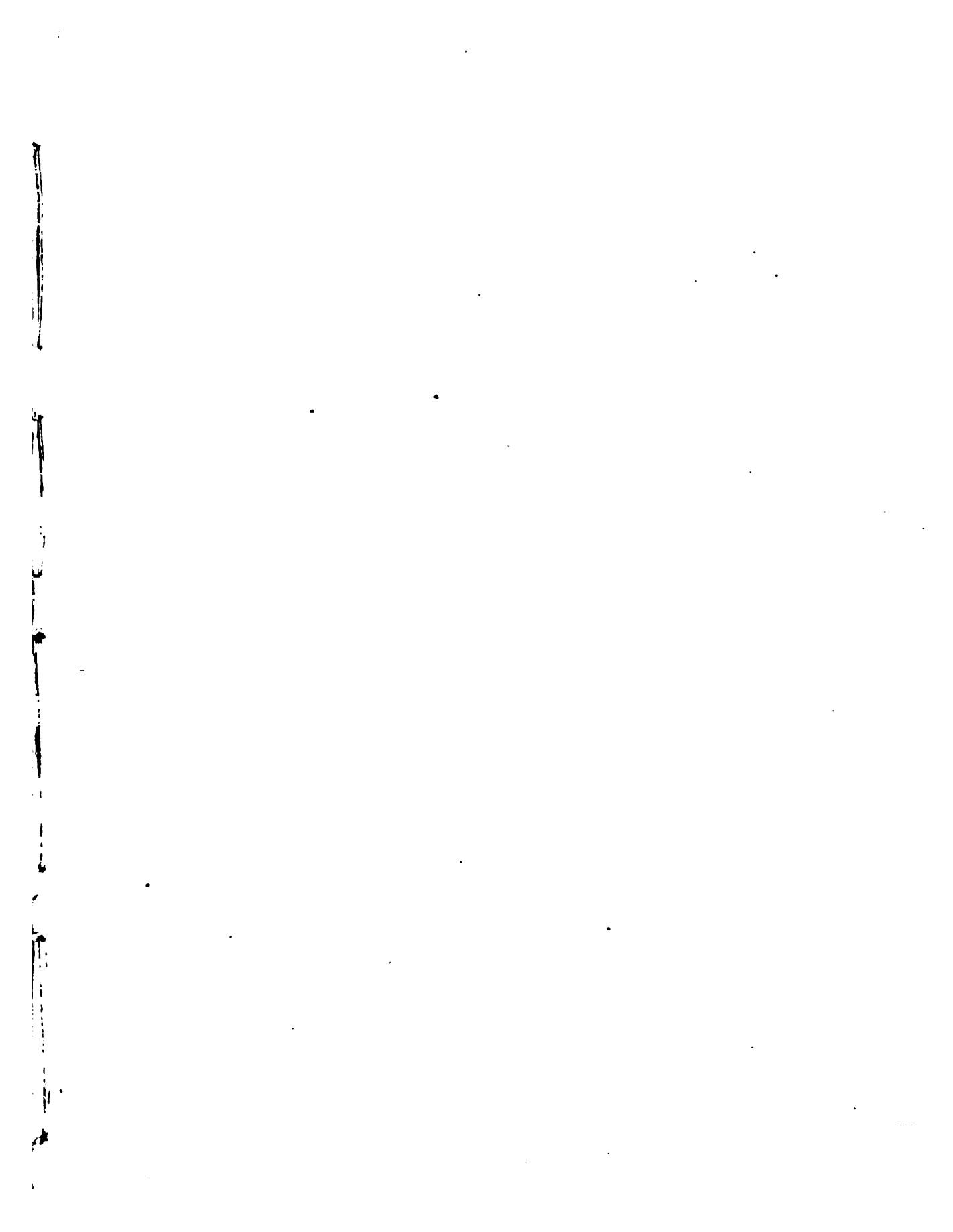
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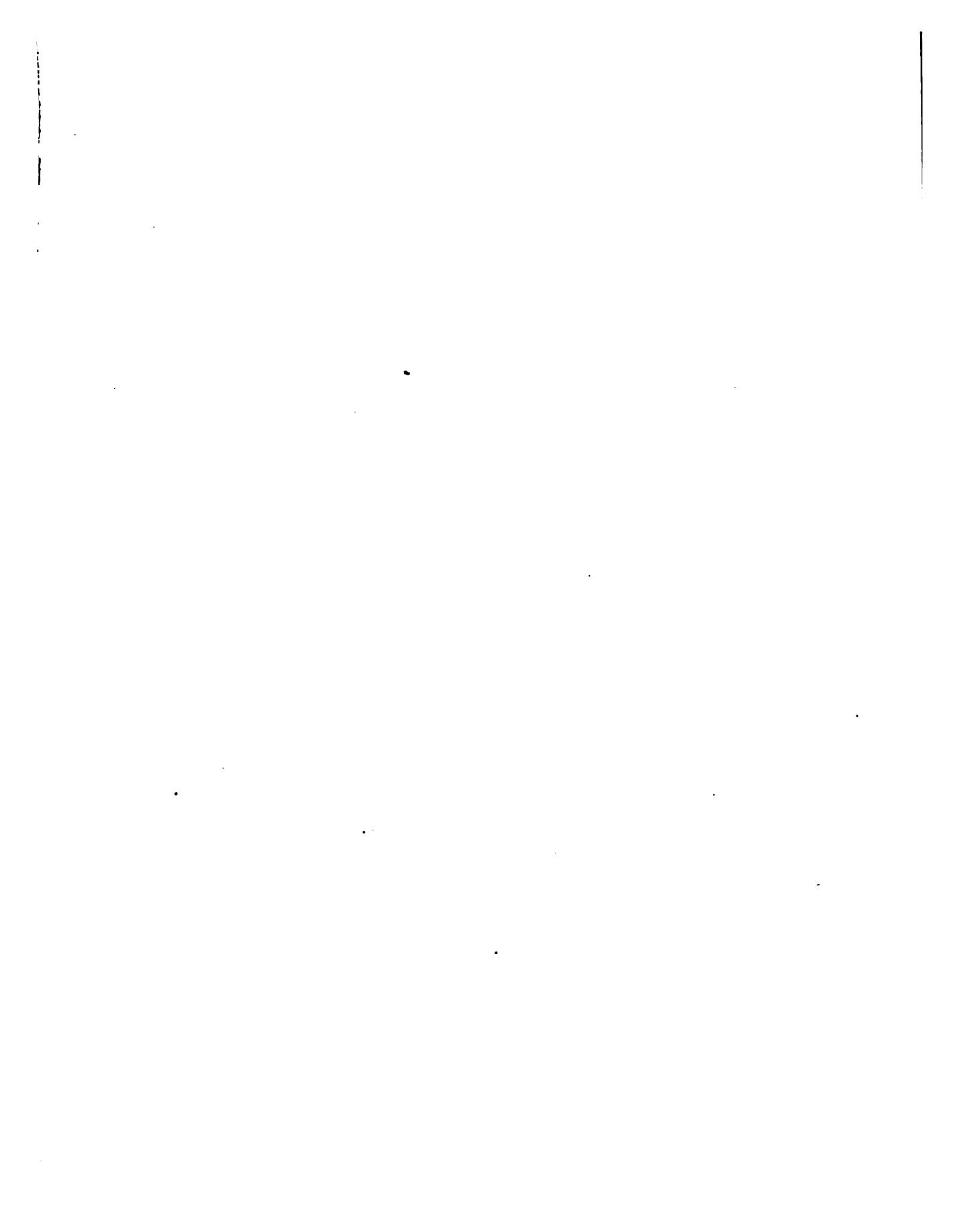
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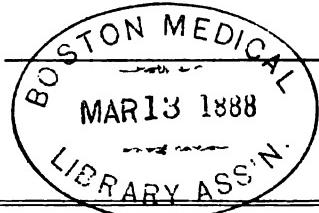
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The Honorable JOHN MILDRED CREED, M.L.C., L.R.C.P., M.R.C.S.E., &c.



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AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES. MAR 13

DRUMINE—A NEW AUSTRALIAN LOCAL ANÆSTHETIC.

DISCOVERED AND DESCRIBED BY JOHN REID,
M.A., M.D., ET CH. M., OF PORT GERMEIN,
SOUTH AUSTRALIA.

THE characters of Euphorbiaceæ are so varied as to make one learn of a plant presenting new properties unconcernedly. When we think of *Euphorbia heterodoxa* with properties like papain of *cascarilla* and *croton tiglium*, what wonder that one of the order should yield an anæsthetic. Dr. Schomburg of the Adelaide Botanical Gardens kindly determined the species for me, and ordered; and so the plant from which I obtained the alkaloid is *Euphorbia Drummondii* N.O. Euphorbiaceæ, from which I have provisionally chosen the name Drumine for shortness and until chemists give us a better. As will appear later on, I use the hydrochlorate, which is very soluble in water, and call it Drumini Chloridum. A tincture is made with rectified spirit, (I believe proof spirit would answer, especially if acidulated with HCl). After standing a few days, it is evaporated to get rid of spirit, ammonia added in excess, solution filtered. The residue, after ammonia odour gone, is dissolved in diluted HCl and the filtrate is filtered through animal charcoal to destroy the colouring matter which is abundant, inactive medicinally, but produces a bluish tinge on the skin, or dark according to amount. This filtrate is evaporated slowly, and leaves the alkaloid. It gives a colourless solution with little taste, almost insoluble in ether, freely soluble in chloroform and water, and depositing from solutions microscopic acicular and stellate crystals, the latter being more numerous in the deposit from aqueous solution. Length of crystals roughly about one to twenty diameters of white blood corpuscle. Crystals deposited from the hydrochloric solution, filtered through animal charcoal, are circular or boat-shaped at the circumference, and stellate, or per-

haps more correctly, discs, as if formed of concentric circles, and with radiating or other figures. They are colourless, and under high power of the microscope, the acicular crystals are in some cases rhomboid in shape. They seem less soluble in chloroform, but whether there are two alkaloids I cannot say, and my limited supply of apparatus prevents further research. The crystals from chloroform solution appear to be smaller and the acicular crystals are more worthy the name in that case. I regret very much that the cocaine I have got contains few of the B.M.J. figured crystals, but they seem to be different. My description will probably give a better idea than a drawing from my pen. Dr. Schomburg informed me that a great many sheep and cattle are annually killed by the plant, which is more poisonous according to the quantity of milky juice it contains. From farmers, etc., I learnt that sheep, bullocks, and horses die in from twenty-four hours to seven days after eating it, all presenting paralyzed extremities, some hang the head as if tipsy, while appetite does not seem to be impaired. At first the weed is avoided and eaten only on account of extreme hunger, but afterwards it is sought after and eaten with great avidity. One gentleman informed me of yellow eyes occurring in some jaundice. I experimented on three cats, one on June 8th, the other on June 15th, the third on August 9th, 1886. The first I partially anæsthetised with CHCl_3 , as I had no assistant. I then by means of a canula injected the solution to the nostrils very freely. After the effects of CHCl_3 passed off, I noticed a great tolerance of blows and interference which cats are apt to resent. There was also a hanging of the head as if inebriated, and a stupid stare when waked up as is often met with in narcotic poisoning. The limbs appeared somewhat paretic. My supply of drug was limited, so after seven hours progressive narcotism, I ended her life with chloroform. The autopsy made immediately afterwards showed bowels healthy but full of undigested food, portal vein full of dark blood and liver, so also veins of chest; bladder half full, urine normal; kidneys natural; clot on right side of heart, left empty; lungs slightly oedematous and bloody at parts, pale generally speaking; brain, medulla oblongata and cord pale, and, excepting a small quantity of red arterial blood, bloodless; brain ventricles empty. The abdominal and intercostal muscles had fibrillary twitchings for some time after death. On June 15, I dropped watery solution—a few drops (estimated 4 per cent. pure alkaloid)—into one of the yes of another cat. In a few minutes it was tolerant

of contact with finger, and the orbicular muscle did not contract firmly as did the other. The pupil was not appreciably dilated. I injected 3 gr. subcutaneously on back. Apart from anaesthesia there was no apparent action produced. As the cat was apparently well on the following day, I gave, by the nostrils and mouth, a large dose. In a few minutes the legs lay quite useless and refused to be stimulated. Breathing was quite slow but apparently difficult. I gave strychnia just as she was apparently dying. The legs first reacted, and some time after there were a few fibrillary twitchings of the face muscles, but no arching of the back, and death very soon followed. A complete autopsy was not made; the liver and abdominal organs were as in the former case. On August 9th, at 9 a.m. I injected into the hind leg of a half-grown cat 10 minima of a 4 per cent. solution. Apart from the local effect, and perhaps a little more tolerance of handling, there was nothing especially noteworthy. The tolerance mentioned applies to a hebetude of all the senses, which increased with the number of injections. I injected about twenty grains into both hind feet, but at 10 p.m. the power of locomotion was present although all the senses were impaired. The cat licked his leg, but at times appeared doubtful if he had a leg; it was freely movable, but in all cases the methods used by cats to defend themselves were not used when I injected, but he called out on my holding the leg—not pricking it. On the 10th, I gave another injection at 9 a.m. Previously there was the apathetic appearance, and pupils reacted to light. Perhaps paresis increased but slowly. At 12.30 p.m. I threw about 3 gr. into mouth and nose, much of it was lost, there fell froth, saliva and mucus, as also happened in the case of the second cat, but whether voluntarily or not I cannot say. At 1.30 p.m. I gave more, and now there was evidently loss of feeling, as tolerance of instrument was very marked; no mucus or saliva from mouth as at 1.30 p.m., only refusal to swallow was marked. The tolerance was noted afterwards. Drops to the eye had the usual effect, with perhaps slight drooping, but no marked action on the pupil. At 5 p.m. I injected min. xv into the right lung. There was no striving until the liquid was thrown in, when two spasmodic coughs occurred, a little mucus was coughed up, and spasms of the extremities (asphyxia of transitory nature) occurred temporarily, the breathing returning to 28 per minute soon afterwards. It continued 28-30 during the previous day. Apparently there were rales for a short time, but at 6 and 6.40 p.m. the breathing was apparently regular. Motion was absent from the affected lung (i.e. respiratory motion); he lay on that side.

At 7.30 p.m. breathing was 40 per minute—he was asleep and rales were audible; the breathing was irregular, and this was frequently noticed on the first day, as if the muscles of the abdomen acted singly and not conjointly. However, after 7.30 p.m. there was an occasional long breath and the remaining ones short; at 8, conscious, but apathetic. I omitted to mention that, when giving the drug by the mouth at 12.30 p.m., he made water, apparently normal and clearand in quantity, the first I have seen since the experiment was commenced. 11th.—9 a.m., respirations 40, otherwise little changed; at 11 a.m. injected min. xv to peritoneal cavity. Respirations soon fell to 30, but at 12.30 were again 42. At 1.40 p.m., injected to back 10 minims. Pupils react to light, there is still apathy, and the lid of the eye to which I dropped the solution appears drooping; the eye is suffused with tears (epiphora), there is no redness or sign of inflammation. The cat bears handling and allows anything to be done without opposition—this is more marked than at 11; when I injected to the peritoneal cavity; respirations 38 at 1.50 p.m., power of locomotion still present. 12th.—Looked fresh, but apathetic; respirations 28. 13th.—As yesterday, but more lively, and had moved from box during night; pupils react to light 14th.—At 10 a.m., injected to neck without opposition, 15 min. of solution; apathy was more marked.—At 11 a.m. min. x to abdominal parietes. There seemed to be a nodding of head and a lying in a listless way, yet he recognized, although apparently with indifference; the fundus oculi was pale and free from congestion. At 11, he made water, evidently with some intelligence; this is the second time since the experiment began. There has been no desire for food or water. In the evening he lay listless with head drooping, pupils dilated in the dark, but react to light. 15th.—7 p.m. sonorous or purring. inspiration and expiration, apparently with some difficulty, but natural when aroused, and natural during the day. R.38; pupils react to light. 16th.—As before but emaciated; breathes easily. At 8 p.m. injected to the left lung, under chloroform, min. x of solution, with anaesthesia and recovery from it. There were spasms (asphyxia spasms), narcosis was carried to stertorous breathing. The animal begins to get somewhat knowing when I lift him up, but still apathetic; pupils react as before. 17th—Listless, as before, breathing, etc., as before; but towards evening hangs the head. 18th—At 9 a.m. he is apathetic, etc., but can move; respiration is regular. I determined to kill him by chloroform inhalation. I found this much more difficult, and there were no asphyxia spasms before narcotism, as previously existed; breathing was pretty regular, and no stertor, as in the former case.

Breathing had stopped for more than a minute ; when I was on the point of beginning autopsy, life began to return and breathing to be regular. I immediately gave CHCl_3 and continued up to death.

P.M.—All abdominal organs somewhat pinched in appearance, no sign of inflammation ; stomach empty, contains a little mucus, no inflammation, rugae, etc., pale; bowels pale; liver somewhat pale; gall bladder full of thick bile ; kidneys pale ; bladder nearly full of natural urine ; testicles and spleen somewhat shrivelled ; parietes pale; heart lax, pale, and contains in the right side fluid half-serated venous blood, otherwise healthy ; pericardial and other serous sacks empty ; lungs both contained half-serated blood, right lung, apart from being tough and shrivelled, apparently normal ; the chest wall contained cicatrix of round form, left lung at part had black dense part somewhat harder than edematous lung, and containing blood evidently partly absorbed ; connective tissue seemed somewhat more abundant at the part. On opening the skull partly serated blood escaped from the longitudinal sinus, not in quantity ; the brain and membranes were evidently healthy, and contained some arterial blood, as did the spinal cord ; ventricles were empty, and there was nothing else abnormal. It is to be noted that the blood formed a fair clot about an hour after death, but the consistence was not altered when the *P.M.* was made.

In the next place, I tried it on my tongue, nostrils, and hand, and found very marked anaesthesia in both cases, even the sense of taste (quinine) was abolished on the side of the tongue to which it was applied. I took small doses, but found no constitutional effects. In a case of sciatica in an old man, in whom I had tried iodide of potassium and ammonia, the first subcutaneous injection (min. IV. of 4 per cent. sol.) in a short time allowed him to stand and walk with comparative ease, pain departing. A second, on the second day following, acted quite as magically, and, to the poor old man's great relief, there has been no return of the complaint. The complaint was chronic, and so bad as to prevent him from moving about except with great difficulty. I used it for toothache, along with carbolic acid, but, as the neuralgia of toothache is very flighty, the least said of it the better. In cases of sprain, however, the speedy effect is probably sufficient to allow us to bid farewell to evaporating and lead lotions. I have seen it work like magic in a boy, the dose being the same, and injected over the adductors of the thigh. I injected some over the stomach, in a case of catarrhal jaundice, on account of pain and tenderness in stomach. Although the injection caused local anaesthesia and a feeling of "deadness," to use the patient's own words, the stomach pain remained. I have used it internally for stomach

pain, but my supply was too limited, and I have seen no cases where the treatment would have been scientific. For tic I have dropped it into the eye and applied locally with success.

The correct interpretation of facts, especially on untrdden ground, is extremely difficult, and on that depends the power of arriving at true generalization of an inductive character. As regards the physiological action, we have it in the case of my cats and stock. Where death arose from an overdose of the drug, paralysis of extremities occurred. Now the nerve supply of these lies close to the posterior nerve cornua in the cord, and we may therefore suppose that the posterior cornua of the cord (sensation) are primarily affected, the poison passing to contiguous parts. I am very much inclined to believe that reported cases of paralysis are neither more nor less than that of my third cat, where movements remained, but the sense relations with the external world existed to a very limited extent, while motion was still possible. The same is illustrated by the absence of hunger but the possibility of eating, the secretion of bile but non-discharge, the secretion of urine and discharge when the reservoir is full, the bowels remaining inactive, unless food is taken in quantity. It will be seen that strychnia, as an antidote, affects only the motor part, while there is possibly an antagonism to a slight extent between chloroform and the drug. The absence of serous effusion, of ecchymosis of tarry blood, of stomach pain, is very significant in the case of a cat that ate and drank nothing for nine days. To be sure there was little fat in the body, the tissues were somewhat lax, but kidneys, although pale, had not diminished in size, and the wounds caused by the hypodermic needle were healthy, just as occurred in the case of my jaundice patient. This is, no doubt, important, seeing that no precautions were taken ; it is probably due to the anaesthetic effects of the drug. There seems to be no special action on the pupil, although the cornea is insensitive by local application. The amount injected to the third cat shows the comparative harmlessness of the drug. In no case have convulsions followed its use. To sum up : cocaine seems to have mixed action, sensory and motor, to cause preliminary excitement—Drmine is almost a pure sensory (no action on the pupil) paralyser, without preliminary excitement ; can be given with comparatively slight, if any, risk. A fungus is generated in the drug solution after some days. Its uses may be summed up as follows :—Nerve troubles of a painful character, not due to a constantly exciting cause which remains potent, operations, irritation, oedema, sprains, and such like ; but I believe there is a brilliant future for this drug in the domain of cerebral physiology

on account of its almost purely topical action. For hydrophobia, and croup with spasms, it would be required to be used with fearlessness and applied either to the nostril, by spray, or with a very fine hypodermic needle into the larynx. I have had no experience in these cases—unfortunately, my supply was exhausted when an opportunity occurred. I trust, however, it will never run the gauntlet of all sorts of diseases, but be used with discrimination. Those daring spirits who inject antiseptics, e.g., corrosive sublimate to the phthisical lung, will probably, in this drug, find a valuable adjunct. Let us hope, from its causing no preliminary excitement, it may be useful in peritoneal and bowel ailments of a painful nature, whether by hypodermic needle or by the mouth. Writer's cramp and its congeners, from the beneficial effects of massage, appear to indicate its use. It does not prevent blood coagulation, although it seems to have a wonderful power of preventing deoxidation; this is probably due to its anaesthetising power, preventing the tissues from reacting to irritation, and demanding fresh blood. The actions of mixed drugs appear to me, by the method of difference, to bid fair to offer a good field for the determining of the true actions of drugs. Tartar emetic seems to be, also in some measure, antidotal. Felz and Ritter write, "La maqueuse présente une injection considérable des capillaires et nombre de petites ecchymoses (infarctus muqueux et sous muqueux)." And so on with regard to other organs, no pallor (*Journal de l'Anatomie, 1876.*) Considering the rationale of poisoning, in the case of stock, I should recommend Glauber's and Epsom salts alone, or mixed with small doses of antimony tartarate, and plenty green feed, in order to eliminate the poison and act antidotally. I have learned from one farmer that green feed has had a wonderful effect in one case—clearing out the bowel and so eliminating the poison. There is one other point to be noted. Our Yankee friends, in their haste to be rich, already supply adulterated cocaine, so we have not had a long time to wait the fulfilment of the *B.M.J.* prophecy. No doubt many letters describing failure of drugs are due to the same cause, and if the greedy mortals who thus inflict needless torture on their fellowmen received one stroke of the cat, or one month's imprisonment, for each offence, we should probably have less reason to complain on this score. Those who have neither time nor opportunity to test the quality of drugs suffer the consequences, unless they depend on the inorganic *materia medica* and those drugs which are not apt to be adulterated. Perhaps a small import tax, with analysis and destruction, without compensation, of spurious drugs, would lead to a better state of matters.

PESSARIES.

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I AM frequently asked by medical men "What is your candid opinion about Pessaries, and also how do you account for the varied opinions expressed concerning them, some men using them on the slightest pretext, and others declaring they never used one in their lives, nor had any intention of using them?" After employing them for the last 20 years, I am perfectly satisfied that there is no displacement of the uterus that cannot be relieved and generally cured by them, and that perfectly independent of the bodily condition of the patient. Like every other good thing, they are frequently abused, especially in unmarried women in mild cases where postural treatment would have sufficed. Like everything else, they very frequently fail, generally through the lack of knowledge of those who apply them. How is this to be supplied? As far as I know, only by constant experience. 1. To use pessaries successfully necessitates the possession of a delicate touch, with which some men are not gifted by nature, and which it is impossible for them adequately to acquire. 2. Some practical knowledge of mechanics, as exhibited by dentists in fitting the mouth. 3. Exhaustless patience and ingenuity in overcoming difficulties, owing chiefly to the existence of exquisitely sensitive spots in the vagina. 4. A large stock of instruments from which to choose.

In reply to the very common question "What is the best pessary?" it might be asked what is the best food for man? A great variety would be an appropriate answer to both questions. Unless a man possesses the four abovementioned requisites he will frequently fail in using pessaries. I have met first-class men wanting in but one of these requisites, and consequently, frequently failing to relieve their patients, and this is inevitable and, from another point of view, unsatisfactory to the patient. An ill-fitting pessary, if too loose, causes much discomfort without relief of symptoms; if too tight, which is the rule, even death may ensue. The commonest symptom is pain, leucorrhœa, which may become purulent, then ulceration into urethra, bladder or rectum, pelvic abscess, metritis, peritonitis, death. Consequently, every woman should be able to remove her own instrument at the onset of these symptoms, which rest and fomentations will then quickly remove. To try and bear it always results in making matters worse.

Frequently preparatory treatment is imperative before applying a pessary to remove local conges-

tions, &c., &c. Some days or even weeks may thus be profitably spent before fitting the instrument, which would otherwise result in failure.

In cases not requiring preparatory treatment, six or eight weeks usually suffice, not necessarily for fitting, but rather for keeping the patient under surveillance. Disturbance of marital relations is seldom needed.

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TWO CASES OF PUERPERAL CONVULSIONS TREATED WITHOUT BLOODLETTING.

BY THOMAS BAIN WHITTON, M.D. Q. UNIV., IREL., L.R.C.S. EDIN., SURGEON TO THE REEFTON HOSPITAL, NEW ZEALAND.

DR. HAYWARD relates two cases of puerperal convulsions treated by bloodletting in the *Australasian Medical Gazette* of May, 1886. During the past year I have had two cases of a similar character with a like successful termination, but in neither case was any bloodletting had recourse to. I will give a brief outline of these cases.

History.—Mrs. C., *æt.* 37, $\frac{1}{2}$ months pregnant of eighth child. I was asked to see her on Sept. 7, 1885, about 1 a.m. The husband informed me that she had retired to rest in her usual state of health, though for the past two or three days she had been complaining of severe headache, it being unusually so this evening. His attention was drawn by her screaming, when he found her in a fit, bitten tongue, &c. She appears to be a very healthy woman, never having had any illness except during her first confinement, on which occasion, the husband states, that she had fits for two hours before birth of child. All her succeeding confinements were normal and easy.

Present State.—In a semi-conscious state; complaining pain in head; pupils dilated; eyelids congested and puffy; tongue lacerated. A convulsion of an epileptic character occurred shortly after my arrival. On vaginal examination, found no signs of approaching labor; os undilated and normal. Having remained with her three hours, and finding no farther return of convulsions, but that she had fallen asleep, I left; ordered Pot. Brom. and Sod. Brom., grs. xv. of each every two hours, and to be sent for should convulsions return.

12 p.m.—Was hurriedly sent for, husband stating that she had two fits within half an hour; found her in a comatose state; pulse, 100; pupils widely dilated, moaning occasionally; made another vaginal examination, which induced a convulsive spasm; found os about size of a

shilling, and the membranes presenting; passed uterine sound rupturing the membranes, and allowing it to remain 10 minutes.

1 p.m.—Had another epileptic fit, biting tongue, &c.; decided to administer chloroform, under which she was kept for the succeeding three hours, and during which time she had five distinct convulsions; commenced a digital dilation of the os, retaining fingers for about ten minutes at a time every half hour or so, until os was sufficiently dilated to allow of passage of the forceps. I noticed that each time of dilation a convulsive spasm occurred, accompanied by moaning and an attempt to rise in bed.

4 p.m.—Os being now sufficiently dilated, forceps were applied, and she was quickly delivered of a dead child, placenta giving no trouble and no hemorrhage following. Having ceased the administration of chloroform, she passed into a tranquil sleep from which she awoke at 10 p.m. conscious. She had no more convulsions.

Sept. 8, 9 a.m.—Found her chief trouble now arising from the lacerated tongue, which prevented both distinct articulation and swallowing; passed catheter only on this occasion; no albumen in urine; to continue the bromides. From this time onward she made a rapid recovery, but she cannot remember anything which occurred from her lying down on the evening of the 6th until 10 p.m. of the 7th. She was about her usual occupation in a fortnight, and has enjoyed good health ever since.

CASE II.

Mrs. W., *æt.* 21, primipara, eight months pregnant. Was sent to see her at 9 p.m. March 12, 1886.

Present State.—Found her in bed, conscious, suffering from intense headache, from which she had complained all day; eyes bloodshot and lids puffy, with a suffusive glow over the face like the onset of erysipelas. She had vomited three times during the last hour; pulse, 115, full and bounding; did not make a vaginal examination as convulsions were not anticipated. Mother, who was present, said that she had been in good health until the previous day; had been able to accomplish her usual work, &c.; that she had never suffered from any disease, nor had received any shock, &c. I had scarcely returned home, a few yards distant, when a messenger returned stating that Mrs. W. was in a fit. Found her in convulsions, tongue bitten, chronic spasms which lasted fully half-an-hour; on vaginal examination found that I could pass finger into os, but as it was so thick and muscular, could not distinguish presentation or membranes; administered chloroform until convulsions ceased; sleeping sound at 9.40 p.m.

11 p.m.—Another attack of convulsions ; chloroform again given from now until 4 a.m. ; she had three farther attacks. I did not keep her continuously under the chloroform, as after five to ten minutes inhalation the spasms ceased. Now found that two fingers could be passed through the os, but as it was about $1\frac{1}{2}$ inch in thickness, very tough and muscular, no presentation could be distinguished. I now attempted to use Barnes' uterine dilators, but was unable to get the smallest one even passed up, so rigid was the os.

March 18, 6 a.m.—Since 4 o'clock no convulsions, conscious ; asking for drinks and complaining of headache ; determined to try the effect of Ti. Gelsem. Semper in dilating, as it was impossible to use forceps, and if the convulsions should not occur for some hours, time would be allowed for os to dilate ; membranes as yet unruptured ; wishing to retain them so as long as possible, given M. XX. Ti. Gels. Semp. every hour ; went home to rest, and to be called should convulsions return.

10 a.m.—Sleeping calmly ; no convulsions ; Gelsem. given regularly ; no farther vomiting ; os dilating slowly ; no spasms on examination.

3 p.m.—Membranes presenting ; no convulsions ; able to insert three fingers into os, but yet about one inch thick ; just able to get finger around inner side of it ; to continue Gelsem. every two hours ; conscious.

9 p.m.—Os thinning nicely, about one quarter-inch ; head present ; membranes unruptured ; haemorrhage free ; no placenta praevia ; the left labium began to swell about the size of an egg, which on being pressed caused blood to flow from the os : a recurrence of convulsions ; had recourse to chloroform again ; used the digital dilation of os as in previous case, but the tumour of labium rapidly increased ; ceased Gelsem.

12 a.m.—Resolved to use forceps as tumour was now the size of half a 4lb. loaf, and I was afraid of being unable to pass them if delayed longer ; the convulsions for the past half-hour had been continuous, and haemorrhage was increasing. After a good deal of difficulty in their insertion, &c., the mother was delivered of a dead child. The haematoma did not increase in size afterwards ; haemorrhage now of normal amount, and no return of convulsions.

2 a.m.—Mother conscious ; expressed herself as feeling well with the exception of the inconvenience caused by tumour. I expressed a quantity of blood from it by hand and placed pillow between legs, but no reduction in size, and not until three days after did it commence to do so. By the twelfth day it had disappeared ; syringed

uterus twice daily with Sol. Pot. Permang. ; catheter had to be used for six days ; no albumen in urine.

March 18.—Breasts troublesome, though from the second day they had been constantly rubbed with equal parts of Lin. Bell. and Normal Liq. Ext. Beilad. (Parke, Davis & Co.) ; temp. 103° and pulse 130 this morning ; 104°, evening ; injected one-tenth gr. pilocarpine at 9 p.m. ; usual restriction as to diet, &c. ; allowed only milk and soda water, and barley water.

March 19, 9 a.m.—Pulse 100, temp. 99° ; breasts flaccid, no milk ; at bedtime injected one-tenth gr. pilocarpine and one-half gr. morph. (in the tabloid form).

March 20, 10 a.m.—Found her pulse 90 and temp. normal ; slept until noon from this date until March 25, when she got up for first time. She made a steady recovery.

March 28.—Found her walking about her room ; no discomfort or pain ; appetite good ; conversed freely on various subjects ; rational in all respects, and did not intend calling again. But fresh trouble was yet to arise, as on the following morning I was hurriedly sent for. Found Mrs. W. had this morning pulled her bedding to pieces, was washing the walls of her bedroom, &c. ; in fact puerperal mania had set in. As she showed an intense anxiety to work about the house, I allowed the nurse to humour her—to walk out with her daily ; was given Hyd. Chloral grs. xx. Pot. Brom. grs. xx. Sod. Brom. grs. x. ter. *in die* for two weeks. Her mother now removed her to her own house, and allowed her to amuse herself with cooking, &c. She gradually recovered, and in six weeks was able to return home to her husband and resume her usual duties.

Remarks.—In both these cases the convulsions ceased on the removal of the child from the uterus. Had they continued afterwards, I fail to see what benefit bloodletting would cause in the case of Mrs. W., she having lost over two pints of blood from haemorrhage. I should have trusted to chloroform inhalation and the administration of Bromides. In the case of Mrs. C. the chloroform had certainly no effect in allaying the spasms, but they ceased on the delivery of the child. In neither of the cases was any albumen found in the urine, and they were both exceptionally healthy and robust females. I remember of having a case of haematoma of the labium occurring two days after delivery with forceps—size, about an egg—and it was reduced without suppuration by poultices and warm applications. In the case of Mrs. W. there must have been a rupture of some vessel in the attempt to use Barnes' dilator, the blood oozing into the connective tissue of the labium.

THE CLAIMS OF THE IMMEDIATE OPERATION IN COMPOUND DEPRESSED FRACTURES OF THE SKULL, WITH TWELVE SUCCESSFUL CASES.

By PHILIP E. MUSKETT, HONORARY SURGEON
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COMPOUND depressed fractures of the skull are, and always have been, interesting to the surgeon, chiefly because of the serious nature of such injuries, and the grave results which are liable to follow cases of this kind.

In the city of Sydney they claim our earnest attention, because it would appear that we get far more than our share of these accidents; yet what is especially gratifying to note is, that the results obtained in their treatment has been most satisfactory.

In a contribution to the *A.M.G.* for July, 1883, being then House Surgeon, I pointed out that in a run of 18 cases under the care of the hon. surgical staff, at the Sydneey Hospital, during a period of 14 months we had seven recoveries; while at Guy's Hospital, out of 51 cases during seven years only 12 recovered; at University College Hospital there were but six recoveries out of 17 cases, and that the operation had not been performed at St. Bartholomew's Hospital for six years.

In the December number of the *Gazette* for the same year, I reported two additional successful cases, one under the care of Dr. Harman Tarrant, the other 14 days afterwards, under that of Dr. Creed.

As to the matter of their frequency in Sydney we can adduce no predisposing cause, for most of the cases which have come under notice have been due to the following:—kicks from horses, blows from bricks, knocked down by cabs, thrown from horseback, falls from a wall, and blasting accidents, which might occur in any city, while our chief peculiarity, the steam tram, has never supplied a single case.

As regards the successful treatment of the great majority of these cases, I take it that the result has been mainly owing to the treatment adopted, especially when we have it on the authority of Erichsen "that he can remember no case of compound depressed fracture in the adult recover which had been left without operation."

Operative treatment, with regard to compound depressed fractures of the skull, has been subjected to change according to the prevailing feeling of the time, for at a former period it was evident that operative measures were very frequently resorted to, the old plan being to excise the piece of scalp corresponding to the bone removed, and allow the wound to heal by granulation.

Then, possibly, as a sequence reaction set in, and nature being left to do her best failed signally in too many cases, though it is difficult to understand why this feeling of inaction dominated, for, as Erichsen points out, it seems unlikely that an operation so lightly undertaken, as it was formerly, could have been very fatal.

At the present time the practice adopted is not uniform, the text books laying down different lines of treatment.

Yet the proper course to be pursued is a very important matter, in fact the operation for the elevation of depressed fragments of the skull, where there is reason to suspect splintering and comminution of the fragments, is essentially an operation of anticipation, the purpose of the operation being the prevention of meningeal inflammation with its fatal issue, and it behoves the surgeon to be prompt and decisive in his action, for to wait and treat symptoms as they arise is to wait too long.

In these cases we are not to be led away by the apparent mildness of the symptoms, for in punctured fracture—the most dangerous variety of all—it often happens that the patient may walk about under the impression that he is suffering merely from a cut head. The truth of this came home to me in one particular case, that of W. F., æt. 15, who had been struck on the head with a crane handle, which had "taken charge."

He was brought up to the accident ward of the hospital by his friends, who stated that he was suffering from a cut head, and that they wanted to have it dressed so that he might go away home. On examining the seat of injury, it was found to possess all the characters of a punctured wound of the skull, though the external table was but little involved.

However the operation of trephining was performed by Dr. Marshall, with Dr. Maclaurin, shortly afterwards, when the extent of the injury became apparent, there being much splintering of the inner table, one fragment the size of a six-pence being driven fairly in on the brain and tearing the dura mater, the result being most successful.

It must be conceded then that the external appearance of any case will give no indication of what has taken place within the vault of the cranium, so that in many cases before any operation for the elevation or removal of depressed bone is undertaken, it is almost impossible to say whether the dura mater is torn or not, and if it be torn we are exposed to the dreaded result of septic meningitis.

In wounds of the dura mater there are many predisposing causes to membranous inflammation, consequent on the fact that the spiculated frag-

ments of the inner table tearing the dura mater, often wound the arachnoid, open up the subarachnoid space, and even lacerate the brain.

In addition to this as in all compound fractures, the access of air, to decomposable discharges, through the fissures of the bone may readily set up septic action and be followed by the symptoms characteristic of meningo encephalitis, with its inevitably fatal result.

The after results to be feared in all these cases of compound depressed fracture of the skull if the depressed fragments are not elevated or removed, and perfect drainage ensured are:—

1. Septic meningitis setting in on the second or third day after the injury. It may be noticed in this connection that convulsions are liable to develop at this period, due to the meningitis spreading over the motor area.

2. A spreading encephalitis, perhaps, running on to suppuration with extensive destruction of the cerebral tissue.

3. If the dangers of acute inflammation have passed off, death may result from softening around the injured part.

4. Sub-acute encephalitis, which may follow even at a remote period.

6. The irritation of the splinters from the inner table may eventually cause chronic meningitis, terminating in suppuration.

7. The same condition may induce traumatic epilepsy.

In the last Braithwaite but one, vol. 92, a writer deprecates operative interference in compound depressed fractures of the skull, his article stating that "trephining is a grave operation," "that the results are not encouraging," and in the concluding part of his communication he says, "that we are not justified in interfering unless there is compression."

Now I submit, his reasoning is based on false premises. In the first place, trephining or what is more preferable and nearly always applicable—the removal of a convenient angle with Hey's saw—is not dangerous, even at the worst it is not dangerous in comparison with the risk incurred by leaving osseous splinters embedded in the dura mater.

As to the statement that the results are not encouraging, this I would venture to deny, as the success met with in the Sydney Hospital has been most gratifying, as will be seen by a brief narration of the successful cases.

Then lastly, as to not interfering till symptoms of compression declare themselves, I fear that, if that were the rule, the time for operation would pass by in too many cases; for it cannot be too strongly insisted upon that the removal of depressed fragments is essentially a procedure for

the prevention of inflammation developing in the membranes of the brain.

In this connection, the following excerpt, from the article "Fracture of the Skull," by William MacEwen, of Glasgow, in Heath's Dictionary of Practical Surgery, will possibly be interesting.

"Regarding depressed fractures, all surgeons agree that the depressed bones ought to be elevated, when they produce symptoms of compression. But the same unanimity does not prevail concerning the treatment of depressed fractures, when unaccompanied by cerebral symptoms; most advising that they be left alone, while a few recommend their elevation. A considerable depression of bone is required to produce immediate and pronounced symptoms of compression, and there can be no doubt that a large number of cases of depressed fracture recover without elevation of the fragments.

"But there is reason to believe that, in not a few instances, although immediate recovery has taken place, and the patient has been discharged from the hospital as cured, yet in the course of months certain cerebral changes become developed, as evinced by motor sensory, or psychic phenomena; and in some, these affections become permanent, or ultimately lead to a fatal issue. It may be alleged that such cases may have had brain-lesions independent of the depression of the bone; but of this there was no evidence, while the fact of the depression of the skull was clearly established. Besides, one never knows by the external appearances to what extent the inner table of the skull has been depressed, although it is safe to say that it is depressed to a greater extent than the outer table.

"The chief reason against the elevation of the depressed bone lies in the fear of exciting inflammatory action in the membranes or in the brain itself. There was good ground for this fear so long as wounds were not kept aseptic; but with the means at present at the disposal of the surgeon it is no longer tenable, and what remains for the surgeon to make sure of is, that the depressed bone or spicula which may be driven through the membranes do not maintain compression or incite irritation, which may lead to inflammatory action of an acute or chronic character. Therefore, when there is marked depression of the skull involving both tables, it ought to be elevated, without waiting for the development of symptoms of compression or of irritation, provided the surgeon has the means of preserving the wound in an aseptic condition. Punctured fractures ought to be treated in the same way, as far as the antiseptic precautions are concerned. They ought to be carefully explored, and all loose fragments elevated."

AN ANALYSIS OF TWELVE SUCCESSFUL CASES OF COMPOUND DEPRESSED FRACTURE OF THE SKULL, TREATED BY OPERATION AT THE SYDNEY HOSPITAL, COMPILED FROM A TOTAL OF TWENTY-TWO SIMILAR CASES.

Number of Case.	Patient.	Age	Date.	History of Case.	Seat of Injury.	Pressure, Symptoms, &c., prior to operation.	Trephining or Hey's Saw.	Surgeon.
1	James M.	29	Aug. 15, 1882 ..	Had been kicked on the head by a horse ..	Frontal bone, right side, a little anterior to, and above the temple ..	Was found lying insensible in a stable. Pressure symptoms well marked ..	Trephining ..	A. J. Brady
2	Walter F.	15	Sept. 19, 1882 ..	Struck on the head by a crane handle which had "taken charge" ..	Left parietal bone in the vicinity of the longitudinal sinus ..	Perfectly sensible. Able to walk into the ward on admission ..	Trephining ..	G. Marshall
3	Edward C. D...	5	Sept. 30, 1882 ..	Dealt a blow on the head with a broomstick ..	Left parietal bone near the posterior superior angle ..	Was unconscious, and in convulsions immediately prior to the operation ..	Trephining ..	M. W. Traill
4	Alice T.	9	Oct. 31, 1882 ..	Knocked down by a cab while running across Pitt-street ..	Two separate fractures involving temporal and parietal bones on each side ..	Symptoms of compression set in shortly after admission ..	Trephining left side, Hey's Saw right side ..	H. J. Tarrant
5	James K.	8½	Nov. 9, 1883 ..	Knocked down by a cab in George street ..	Fracture extensive in area, involving both parietal bones ..	Marked pressure symptoms existed at time of operation ..	Hey's Saw ..	A. J. Brady
6	George O.	55	Jan. 16, 1883 ..	Dealt a blow on the head with a brick ..	Right parietal bone, with ruptured meningeal artery ..	Marked symptoms of compression ..	Trephining ..	M. W. Traill
7	James W.	25	June 11, 1883 ..	Blasting accident at Waterworks ..	Right parietal bone towards exterior margin ..	No pressure symptoms. Perfectly sensible and able to walk ..	Hey's Saw ..	H. J. Tarrant
8	John McG.	10	Sept. 8, 1883 ..	Caught by wheel of machinery and thrown away some distance ..	Right parietal bone towards posterior border ..	In a semi-comatose condition on admission ..	Hey's Saw ..	H. J. Tarrant
9	Squire A.	23	Sept. 20, 1883 ..	Blasting accident at the Hawkesbury ..	Frontal bone on the right side ..	No symptoms of compression on admission ..	Hey's Saw ..	J. M. Creed
10	William M. B.	7	April 7, 1885 ..	Fell from a wall a distance of nearly 10 feet ..	Left parietal bone near the median line ..	Compression symptoms well defined. Pupils irresponsive to light. Unilateral convulsions right side ..	Hey's Saw ..	P. E. Muskett
11	Walter O. S.	7	July 4, 1885 ..	Fell from a wall on some sharp stones a distance of 7 feet ..	Frontal bone a little anterior to and above left temple ..	Pressure symptoms well marked. Pupils dilated, left especially so. Unilateral convulsions right side ..	Hey's Saw ..	P. E. Muskett
12	Michael McN.	24	Aug. 29, 1885 ..	Brick slipped from a "skiff," and fell on his head, a distance of 8 or 9 feet.	Left parietal bone a little to left of median line ..	No symptoms of compression, quite rational, able to walk ..	Hey's Saw ..	P. E. Muskett

REMARKS.—It is interesting to note in connection with the above analysis, Nelaton's statement that of the 16 cases of injury to the head in which the Trephine had been used in the Parisian hospitals during 15 years, all terminated fatally.

In the above table I have made a distinction between the cases in which the Trephine proper was used, and those in which Hey's Saw was employed, for Erichsen in describing 46 cases reported by Lenta, of New York, with only 11 recoveries, takes care to allude to the fact that Lenta has not made any such distinction.

I apprehend that Bryant does not recognize any practical difference between the two operations, for in writing under the head of "The Operation for Trephining, or for the Elevation of Depressed Bone," he states that at Guy's Hospital there were only 12 recoveries out of 51 cases during a period of 7 years, so that he evidently regards the two operations, viz., Trephining proper and the use of Hey's Saw as identical in effect.

One is obliged to believe, however, that the use of the Trephine is seldom necessary, as in nearly all cases by cutting out a V shaped piece with the Hey's Saw from some convenient situation, an equal space for using the Elevator is availed of, without the necessity of removing so much bone.

First Case.—James M., æt. 29, admitted August 15, 1882, with compound depressed fracture of the right frontal bone. He had been kicked on the head by a horse, and was found lying insensible in a stable. On arrival at the hospital the compression symptoms were found to be well marked. Dr. Brady performed the operation of trephining shortly after admission, when the inner table was found to be extensively comminuted. In this case the comminution was so great as to preclude the idea of recovery without operation, the result being successful.

Second Case.—Walter F., æt. 15, admitted September 19, 1882. This was Dr. Marshall's successful case, which I have cited in a previous portion of this paper.

Third Case.—Edward C. D., æt. 5, admitted September 30, 1882, with compound depressed fracture of the skull. He had been dealt a blow on the head with a broomstick intended for someone else, and on arrival at the hospital was unconscious and in convulsions. Dr. Traill trephined shortly afterwards, and the case ended in speedy recovery.

Fourth Case.—Alice T., æt. 9, admitted October 31, 1882. She had been knocked down by a cab in Pitt-street, while walking across the road. On admission she had a compound depressed fracture of the skull about the size of a five-shilling piece, on each side of the head, above the ear, and symptoms of compression set in shortly after admission. This case was looked upon as well nigh hopeless, but Dr. Tarrant performed the operation of trephining on one side, and on the other removed an angle of bone with Hey's saw for the purpose of elevating the depressed fragments. This case terminated most satisfactorily.

Fifth Case.—James K., æt. 8½, admitted November 9, 1882. He had been knocked down by a cab in George-street. In this case there was an irregular fragment involving both parietal bones, the fractured portion being mobile, but depressed, marked pressure symptoms being present. Dr. Brady operated with the Hey's saw and elevator in this case, which did well.

Sixth Case.—George O., æt. 55, admitted January 16, 1883. He had been struck on the head with a brick, at North Shore. On arrival at the hospital he had symptoms of compression, with compound depressed fracture of the skull and ruptured meningeal artery. Dr. Traill trephined shortly after admission, and the result was successful.

Seventh Case.—James W., æt. 25, admitted June 11, 1883. He had been injured by a blasting explosion at the Waterworks. There was a compound depressed fracture of the skull involving the right parietal bone. There were no pressure symptoms, but, in view of the nature of the

accident, Dr. Tarrant performed the operation of elevating and removing the depressed fragment with the Hey's saw and elevator. The inner table of the skull was much splintered, and fragments of stone driven in by the explosion were found between the skull and dura mater. This was completely successful.

Eighth Case.—John M. G., æt. 10, admitted September 8, 1883. He had stooped down under the driving pulley of a stationary engine to pick up some object, when he was caught by a rapidly revolving wheel and thrown some distance. There was a compound depressed fracture of the right parietal bone. On admission he was in a semi-comatose condition, with the pulse slowed down somewhat. Dr. Tarrant used the Hey's saw and elevator, when the inner table was found to be comminuted and splintered to the extent of nearly two square inches, with the dura mater torn as well. This boy made rapid progress to recovery.

Ninth Case.—Squire A., æt. 23, admitted September 20, 1883. He was a navvy, engaged on the Hawkesbury in a blasting operation; after firing the charge, he retired to what he considered a safe distance, but a large boulder of bluestone, propelled against a tree, glanced off, and was shot against his forehead. He was found to be suffering from a compound depressed fracture on the right side of the frontal bone, a piece nearly 1½ inches long, but very narrow, being depressed. Dr. Creed saw the case soon after admission, and though no symptoms of compression were present, in view of the nature of the accident, he considered it advisable to operate. A piece of the frontal bone was removed with the Hey's saw, when the inner table was found to be greatly broken up and depressed; the dura mater being torn as well. The patient made an excellent recovery.

Tenth Case.—William M. B., æt. 7, a schoolboy, admitted April 7th, 1885. While playing with some other children he fell from the wall of a house in course of erection at Redfern, a distance of nearly 10 feet, sustaining severe injury to his head. Becoming unconscious about 10 minutes after the accident, he was picked up and carried home, when convulsions soon came on, and he was immediately brought to the hospital. On admission he was found to be suffering from a compound depressed fracture of the left parietal bone, from which there was considerable haemorrhage. He was insensible, with the pulse somewhat feeble, and the respiration slow and laboured; the pupils were unresponsive to light, and the left dilated; convulsions involving the upper and lower extremities were present; at first both sides were equally affected, but, subsequently, those on the right side became more marked. From the nature of the accident, and the condition of the patient, I deemed

it advisable to operate. By taking advantage of the opening already fashioned by the injury, it was only found requisite to enlarge it somewhat and make a transverse incision to give additional room. The flaps were then carefully freed, special care being taken to preserve the pericranium. On reflecting the flaps and pericranium the true state of matters became clearly revealed. There was a circular aperture of $1\frac{1}{2}$ inch diameter, in the left parietal bone, about 1 inch from its posterior superior angle, so sharply defined as to present the appearance of being "punched" out. No fissure radiated from the intact parietal bone, but the external table could be seen much depressed, lying at the bottom, as it were, of the aperture. As it was found impossible to extricate the bone, a small wedge-shaped piece was removed with the Hey's saw from the encircling sound portion, when the elevation and removal of the depressed portion of the outer table became comparatively easy. On the removal of this latter, the inner table was found to be extensively comminuted, the dura mater being torn by a sharp angle of one of the fragments. The loose and depressed portions of the inner table were then removed, the pericranial flaps replaced, and the scalp approximated with silver wire, care being taken to give ample exit and drainage at the dependent part. After the operation, the convulsive movements quite ceased, and the patient slept till the following morning, when he awoke somewhat suddenly and remembered about the accident.

April 9th.—Second day after operation; patient passed a good night, and had a fair breakfast, appears quite comfortable; no bad symptoms being present. It is not necessary to give the fuller details of this case, as the patient progressed favourably to recovery, leaving the hospital in the course of two or three weeks.

Eleventh Case.—Walter C. S., set. 7, schoolboy, admitted July 4, 1885. The history of the case, as supplied by the father, was, that he had fallen from a wall on some sharp stones, a distance of six or seven feet, that he was picked up unconscious and in convulsions, and was immediately brought to the hospital at 6 p.m., the operation being concluded and the patient in bed by seven. On admission he was found to be suffering from a compound depressed fracture of the frontal bone, a little anterior to and above the left temple. The wound was a little over one inch in length, and brain matter was issuing from it. He was in a state of insensibility, the pulse slow, and the breathing stertorous; the pupils were dilated, the left more so than the right, and both were unresponsive to light; there were also unilateral convulsions, the right side being affected. In view of the symptoms I considered it necessary to operate.

A semi-lunar shaped flap with the convexity downwards, was dissected upwards, by enlarging the two horns of the wound. The pericranium was then carefully separated from the bone, to an extent sufficient to give free access to the seat of injury. It was then found that a portion of the external table, a little more than an inch in length, and half-an-inch in width, was depressed and drawn fairly in. On removing a small wedge of bone with Hey's saw from the sound bone near the outer extremity, this depressed piece was elevated and removed with the curved bone forceps, when the extent of injury to the inner table was at once recognised. This was extensively comminuted and depressed, a corner of one fragment had pierced the dura mater, opened up the arachnoid space and lacerated the brain, for brain matter was escaping. The loose pieces were elevated and removed, the pericranial flaps readjusted, and the scalp approximated with silver wire, with ample exit for drainage inferiorly. Patient better in every way since the operation, the convulsions ceasing before midnight. As the after progress of this case in somewhat interesting, I purpose quoting more in detail the history of the case from the hospital report.

July 5.—Patient is doing well; was restless after midnight, but is quiet and conscious this morning; temp. 100°, p. 126°; no convulsions have recurred. Evening: dressing changed; temp. 100·2°, p. 126°; taking his milk well; Hyd. Subchlor. gr. iii.

July 6.—As the bowels were not relieved an enema was given, which acted well; wound looking healthy, but as there was a little discharge, hot boracic lint was applied; patient quite conscious, and taking his nourishment well; temp. normal in morning, 100° in the evening.

July 7.—Very restless, to have a mixture of Pot. Brom.; boracic dressing continued; in the evening became more quiet. As there seemed a little tension in the sutures, one was removed and another divided, when a little pus and what appeared to be a speck of brain matter came away; to have Hyd. Subchlor. gr. iii. Morning temp. 100°, evening temp. 99·6.

July 12.—Is doing well; no head symptoms; there is a small hernia cerebri forming at the lower angle of wound.

July 14.—Wound looking healthy; hernial protruding slightly decreased.

July 17.—The hernia cerebri is now the size of a cherry, and pulsates slightly; otherwise quite well.

July 28.—Gentle pressure with a sponge and gauze bandage has been tried over the swelling, and it has now subsided.

August 4.—The wound has now completely

healed up, though pulsation is still communicated. Patient leaves hospital to day.

Twelfth Case.—Michael M., set. 24, labourer, admitted August 29, 1885. He was working at the new building for Her Majesty's Theatre, in Pitt-street, when a brick slipped from a skiff in its ascent to the upper story, a distance of about 8 or 9 feet, and fell with the sharp corner on his head. On admission he was conscious and able to walk; there was a Y shaped wound over the crown of the head, a little to the left of the middle line; the finger passed into it, detected a depressed portion of the left parietal bone. He complained of slight numbness in his right hand, but the grip was firm. There was no other evidence of motor or sensory paralysis. In view of the injury presenting many of the dangerous features of punctured fracture, it was decided to elevate and remove, if necessary, the depressed portion. The patient being placed under chloroform, I enlarged the original wound at each of its three extremities, and reflected the scalp to an extent sufficient to give access to the lesion, the pericranium being carefully preserved and reflected at the same time. A wedge-shaped piece was then removed from the intact bone contiguous to the anterior margin of the fracture, with Hey's saw. The depressed portion of the external table, triangular in its general outline, was then removed. The fragments of the inner table, which had been driven in under the sound bone, came then clearly into view, and were only extracted with some difficulty, being closely wedged in and depressed, when it became apparent that the dura mater had been torn by a sharp angle of one of the comminuted pieces. All sharp and angular projections of the sound bone were then carefully removed with the sharp bone forceps, the pericranium was then replaced, and the wound drawn into apposition with three silver wire sutures, care being taken to leave exit for drainage. As there was a little oozing a cup sponge was kept lightly in position over the wound with a gauze bandage, the ice bag applied to the head, and an enema administered.

Aug. 30.—Is rather restless this morning; complains of slight numbness of right hand; the grip is weakened. To have Hyd. Subchlor., grs. v., followed by White House mixture in morning.

Aug. 31.—Has slight headache; paresis of right hand slightly increased; no paralysis of other parts; wound looks well.

Sept. 4.—Right arm paralysed; speech also affected; fluid runs out at right side of mouth; is dull and stupid; sensation appears impaired in right leg; bowels relieved with Hyd. Subchlor. and White House mixture.

Sept. 5.—Right arm and leg totally paralysed;

sleeps a good deal; no vomiting; pulse regular, though feeble.

Sept. 6.—Has aphasia; passed his urine in bed this evening; bowels relieved by aperients.

Sept. 10.—Is decidedly improving; the pulse is stronger, and patient is able to speak

Sept. 28.—Is able to move and use both right arm and leg; can speak quite distinctly; is free from headache.

Oct. 7.—Has developed an attack of tonsillitis, having apparently caught cold while out on the verandah, where he has been allowed to go for the last two days.

Oct. 10.—Quite himself again. Leaves the hospital to-morrow morning.

ON TUBERCLE, CONTAGION AND HEREDITY.

By F. W. ELSNER, F.R.C.S.I., MELBOURNE.

It seems to me that very few practitioners in Australia "believe" that tubercle is contagious. I emphasize "believe," because it seems strange to anyone acquainted with recent pathology that there should be a question about the matter. Let us shortly review a few of the facts relating to this serious matter and then sum up, having first of all premised one or two axioms before we proceed to discuss the theme, and these are: (a), that when consumption or phthisis is spoken of, we mean *tubercular* consumption or phthisis, and nothing else; (b), that when we use the word *contagion*, we allude to the capability of transmission from one person to another in the same way that measles or small-pox is conveyed, to the exclusion of supposed hereditary transmission, which I shall endeavour to disprove at the same time.

There can remain no material difference of opinion when two sides will agree that tubercle and its manifestations, as shown by Virchow, &c., whether these be in the lungs, the brain, or the peritoneal cavity, is a distinct disease, and not merely an inflammatory product, and that caseous pneumonia, catarrhal pneumonia, fibroid phthisis, cirrhosis of the lung, knifegrinder's phthisis, or whatever else it is often called, should occupy a separate category in our nosology, and having admitted so much, the opponents of the contagiousness of phthisis leave but few arguments in favour of their own theory; but to this I will return presently.

At the beginning of this century Laennec taught the contagiousness of phthisis, of which he died himself, having contracted tubercle at a *post mortem* on a very tuberculous subject, during the performance of which he wounded himself; he described his own case, and was examined by Recamier and Meriadec Laennec, who discovered

pectoriloquism under the left clavicle and in the supra-spinal fossa; subsequently Ambrose Laennec, and Ollivray observed the same in the infra-spinal fossa, and made no doubt of the existence of softening tubercles in the lungs. Then the teaching of Laennec was forgotten, and never revived thoroughly until animal experiment corroborated his theory, and the discovery of the tubercle bacillus by Koch put the keystone into the arch which it took so long to erect. The labours of Villemin, of Rindfleisch, of Klebs, of Buhl, and others, tended to prove the inoculability of tubercle; for a disease like syphilis, which is both hereditary and contagious, it has been sufficient to prove its inoculability, but in the face of all that has been accomplished in this direction for phthisis it still remains a fact that there are medical practitioners who doubt that it possesses this property.

In 1881 appeared the late Julius Cohnheim's valuable essay, "Die Tuberkulose vom Standpunkte der Infektionslehre," in which he ably argued in favour of the contagiousness of tubercle, and hinted that it merely required the discovery of a specific germ to set the whole matter at rest for ever. The year following Koch announced his great discovery; but in 1886 no further advance has been made, and the public are allowed to remain in blissful ignorance of the malignant nature of the disease (as far as they and their belongings are concerned) from which their relatives or friends may be suffering, and jog along quite contentedly, nursing the adder in their bosoms as if these indefatigable workers and true philanthropists had never existed. "Consumption is hereditary, it is fate if we get it, we cannot avoid it, if we are doomed to inherit it." Such are the answers made when it is suggested that too constant attendance on a phthisical patient might prove injurious. Let us then endeavour to demolish this hereditary theory and show what dangers it carries with it. First of all, no child has ever been born with tubercle like they are born with syphilis—a true hereditary disease (Cohnheim). I am, of course, aware that cases have been recorded in which children were said to have been born with tubercle in various situations, but Wolff and Virchow, in No. 25 of the *Berl. Klinische Wochenschrift*, April, 1886, throw discredit on them quite recently, and I myself have never seen such a case nor have any of the numerous colleagues whom I have asked about it, neither has any investigator of note ever seen such a curiosity or placed it on record. It cannot be denied that a predisposition to the reception of tubercle may be inherited in certain of the tissues, but this is not what we require to establish heredity in disease. Secondly, nearly

every practitioner will know cases in which several generations have escaped the supposed inheritance, and cases are known in which twins have been attacked singly, the other never developing a symptom of any kind, whilst the afflicted one died. At one time it was considered a dead certainty that all children born of tubercular parents must inherit the dread disease, and yet I remember families at home in which perhaps only one member has been attacked, and others in which all the children have escaped up to date. Cohnheim's explanation for this is that, given a phthisical patient in a family, the conditions are present for the conversion of the poison to the other members of the family. For instance, the mother is phthisical, the child absorbs the poison through the milk; the husband is diseased, he communicates the disease by his exhalations, or bacilli from a tubercular testicle are mixed up with the semen and conveyed into the genital apparatus of the wife; further they do not get, for they cannot ride on the spermatozoa into the Fallopian tube and settle in the ovary, nor can they get there of their own accord as they possess no movements of their own, but they are possessed of longevity and may set up tubercular processes in the uterus and the genital tract (Virchow). Virchow also stated on the 14th April of this year that he had long ago pointed out that the greater part of the so-called congenital tubercular processes were nothing more nor less than syphilis, and the rest were cases of inflammatory processes which could not be called tubercular on any pretext. *He has never met with a case of congenital tuberculosis*, and even if a few cases had really ever occurred he believes that they would prove nothing, taken alone. The case of Baumgarten, who stated he had found a bacillus in an ovary, according to Virchow, proves nothing, for the ovum did not arrive at maturity; in fact the bacillus killed it, and he doubts whether a delicate ovum would ever mature with a bacillus in its belly. To return to contagion, however, I would ask whether any precautions are ever taken to prevent the possibility of its occurrence in phthisical cases such as are taken for instance in typhoid, the degree of contagiousness of which we are even now unable to precisionise? Is the patient's sputum disinfected, his bedding destroyed, his dejections buried, or the utensils he uses kept for his use alone? Does the wife cease to sleep with him, his children to caress him, or his nurse ever stir from his bedside to take the fresh air as she would if he had a specific fever? When he dies, is his room disinfected and whitewashed and left uninhabited for some time afterwards, or do not his relatives hang over the body until the coffin-lid is screwed down? To all

these questions the answer is, No. I have myself seen a beautiful girl hang on the lips of a man who died six hours before of phthisis, and I need scarcely add that she died of the same disease nine months later. When a case of small-pox or supposed small-pox occurs, a whole colony is thrown into a state of panic, and the quarantine that is established is wonderful to see. Every precaution possible is taken to prevent it from spreading, and it is almost the same with other dangerous infectious diseases. But what is done in the case of phthisis, that malignant affection which carries off as many persons annually, if not more (when we include the whole tubercular series), than the whole of the exanthemata and general diseases taken together? Nothing whatever; and yet its contagiousness is apparently well-known, for it has been proposed to deal with the rabbit pest by inoculating the rodents with tubercle, although it is not so well known that Koch has succeeded in infecting dogs, cats, and monkeys—which were hitherto considered to be invulnerable to bacillus—with it also. Everything is done to perpetuate the disease, it being taken for granted that it is not contagious and can be hereditarily transmitted, and even the easily-obtained ocular evidence, albeit microscopical, of a specific germ will not suffice to convince the old school of its errors. For no other disease has it been possible to obtain proof so decided of specificity except for syphilis, of which I have often heard it stated that if a germ could only be discovered the theories would be for ever set at rest in regard to it. For syphilis at last a germ is stated to have been discovered, but our knowledge of it is so complete that we do not now require it in order to take precautions to prevent infection from that source, and in tubercle the desideratum has been found sometimes—the missing link as it were; and yet it is all one to us that from a single bacillus colonies of flourishing bacteria may be cultivated under our very eyes if we will only open them *secundum artem*.

Not hereditary but specific, contagious, and malignant is tubercular phthisis and all tubercle, although pulmonary exhalations are most to be feared in this respect, and its germ will, when introduced into any caseating processes in the system, convert them into genuine tubercular and, therefore, malignant processes which destroy the life of the afflicted one sooner or later.

No means that we are at present in possession of can destroy the virulence of tubercle, our germicides being too feeble and our therapeutics hitherto being directed in no particular direction, except towards the alleviation of symptoms, and with what success? Could we in the initial stages of consolidation of the lungs operate as is

done, and correctly too, in the case of "strumous" joints, and remove what disease is there, so long as general infection had not begun, we might hope for a cure, perchance; but, even then, what success has attended the excision of the primary chancre in syphilis on the same principles? We cannot tell, without microscopical examination, whether bacilli are there or not—in other words, we operate on the off-chance.

Say what we will, or prove what we may, there are always men who will not "believe" in the contagiousness of tubercular phthisis, and these in the foremost ranks of the profession too, e.g., Sir Andrew Clarke, quoted by Dr. Bird in his recent paper (*Australian Medical Journal* for September, 1881), says "that the occurrence of the same bacillus in caseous pneumonia and in tubercular phthisis tends to minimise the importance of the organism." But, I would ask, does it not tend to heighten its importance? Has it not by its very presence in caseous pneumonia converted that simple product of retrograde metamorphosis in pathology, caseation, into a compound, specific, malignant disease, which is nothing more or less than tubercle? Before the bacillus got into the caseating tissue its nature was tubercular; now by its presence it has converted the caseating mass into a tubercular focus; the bacilli are identical and the diseases have become identical. This corroborates what Niemeyer empirically discovered long ago, viz., "that the danger which a patient with caseous degeneration, say of lymphatic glands (scrofula), incurred was that he might at any time become tuberclosed," and yet Niemeyer died before the bacillus was ever dreamt of. He, astute observer that he was, anticipated by many years that which has since become a properly authenticated scientific fact, but which, in the deplorable fashion of the day, is ignored by those who ought to promote the knowledge of it, and scoffed at by the empirical and ignorant. A noble monument, truly, to raise over the ashes of such a lover of men! When I say that no case of tubercular phthisis has ever been cured, I am stating a very simple fact which, narrowed down to its limits, admits of verification in several ways. Suppose the sputum of every phthisical case is examined for bacilli; suppose a *post-mortem* is performed on every case of diagnosed tubercular disease, and it will be found that in the former case recovery never follows, whilst in the latter tubercles will be found as surely as cancer cells are found in preparations of carcinomatous tissue. If a case of so-called tubercular meningitis recovers, where is the evidence that it was tubercular? If tubercular peritonitis be diagnosed, where is the verification if the patient recovers? Would the most ardent histologist cut down on a man's peritoneum and remove

sections? Or, if a child recovers from the chimerical disease yclept "tabes mesenterica," where is the evidence that tubercle existed?

If a sputum does not contain bacilli, the case is not of tubercular origin, so much will, I have no doubt, be admitted; there is then no reason, although there be cavities, although there be physical signs enough to satisfy any "specialist for diseases of the chest and liver," as they playfully call themselves, why recovery should not take place. Nevertheless, as in all other contagious and infectious diseases where a poison and a ground for the reception of the same is required, such a patient with caseous pneumonia, fibroid phthisis, etc., furnishes all the conditions necessary for the development of tuberculosis, the danger of which, as Niemeyer laid down, hangs over his head like the sword of Damocles. If the bacillus enters the body, the downward course of such a patient is certain and rapid. Theoretically correct, inhalations are practically useless when the dread germ is found in the sputum; our germicules are too mild to do aught else than to keep the secretion of cavities sweet and to lessen its quantity, but their use will be demonstrated when by their means we prevent the introduction into the lungs of the bacillus until the cavities have had time to granulate and to cicatrize, even as in wounds by our antiseptic dressings we prevent the introduction of germs of pyæmia and erysipelas when properly carried out until union has taken place. And thus we can tabulate by the aid of the microscope and the staining fluids now in general use at clinical hospitals even at home, a series of cases which are benign, a series which are doubtful and dangerous, and a series which are malignant and hopeless, like the old clinical classification of tumours into "benign, recurrent, and malignant." Inhalations of watery vapour have, it is stated, been tried on a large scale in Victoria, but from the very nature of things they have utterly failed, as might have been expected, when we remember that all the greatest authorities on climatic treatment have invariably recommended dry, hot climates, the tendency lately having been to recommend cold, dry climates, e.g., that of Davos-am-Platz (Switzerland), and Colorado, U.S., or Canada during the winter. Such being the practice, how comes it that moist, watery inhalations have ever been advocated? Does not a moist heat afford the very essentials necessary for the multiplication of spores and germs within the organism, and is it forgotten that consumptive patients have to quit tropical regions during the monsoon or rainy season on account of their condition being aggravated by the moist air? Is there no ship's surgeon who has noted that most

of his consumptive patients die during the prevalence of the monsoon, or in rainy weather generally. It is high time that empiricism ceased in this branch of the profession, and that practitioners availed themselves of the countless aids to diagnosis and treatment which the modern discoveries in regard to tubercular disease have gradually contributed.

I call no examination of a phthisical patient complete which does not embrace the microscopical examination of the sputum for bacilli, and the appearance of even a few is to my mind as grave a point in the prognosis as is the appearance of cancer cells in a scraping of a tumor.

(To be concluded in next issue.)

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE B.M.A., ANNUAL MEETING,

Held at the Adelaide Hospital, June 24th, 1886.

Mr. Hayward (in the chair).

PRESENT:—Prof. Watson, Drs. Cawley, Gardner, Görger, Henry, Lendon, Mitchell, Peulton, Robertson, Stewart, Symons, Verco, Mesars. Clindening, Corbin, Giles, A. A. Hamilton, Horneck, Jay, Lloyd, McGowan, Vaughan, and Cleland.

The minutes of the meeting held May 27th, 1886, were read and confirmed.

The hon. secretary then read the following

ANNUAL REPORT.

The Council has to report that during the past year several questions affecting the profession generally have received their serious consideration. The most important of these was how best to cope with the growing evil of persons practising and professing a knowledge of medicine without having received any recognised certificate of having undergone the requisite training. The opinion of the whole profession in the colony was united, and the result, in certain propositions, appears in the "Proceedings." It is hoped that the deputation for which arrangements have been made will lay them before the Premier, and by its influential character necessitate some action being taken on the part of the Government. The fact that over 5 per cent. of the certificates of the cause of death forwarded to the General Registry Office are from persons possessing no recognised medical qualification, makes it evident that the evil has now attained such dimensions that longer apathy on the part of the authorities cannot be maintained without risk to the community. It may be, however, a source of questionable satisfaction for us to know that this proportion of uncertified causes of death is exceeded in some large towns in England (Hull, 5.6 per cent.; Sheffield, 6.1 per cent.; Halifax, 7 per cent.; Oldham 7.5 per cent.), whilst others, such as Liverpool with 4.8 per cent. follow closely. London seems to carry off the palm with about 1 per cent. The *Lancet* pertinently points out that there exists an inverse ratio between the uncertified causes of death and the holding of coroner's inquests. It further adds that "this unqualified practice simply means imposition on the ignorance and carelessness of the poor" and that the co-operation of the coroner "is indispensable to protect the poor from this dangerous form of imposi-

tion." Your Council feels strongly on this matter, and on the importance of action being taken, and has specially dwelt on the subject in the hope that its successor may with energy continue to urge the matter to a successful issue, and that during the coming year a suitable Medical Act may be passed. In connection with this subject, as showing the false position in which the profession is often placed by the actions of persons having no recognised medical qualification, and as a necessary consequence, no professional sense of honour and morality, may be mentioned the action that our president was compelled to take to refute certain imputations made by a Mr. Turnbull in the *Advertiser* against a certain supposed medical practitioner. The president clearly pointed out that the person to whom the remarks applied was not in any sense considered a member of the profession, nor did he possess any qualification entitling him to be recognised by the Medical Board of the colony.

Your Council also in view of certain unfortunate cases of prisoners dying soon after arrest, forwarded a letter to the Commissioner of Police, drawing his attention to the necessity of having greater facilities provided for procuring medical attendance. The course of action in other large towns was also pointed out. Want of funds seems at present a drawback to any practical steps being taken.

Your Council has authorised the preparation of tables and charts showing the distribution of the mortality over the colony, a general outline of the temperature and prevailing winds, and the relation between temperature and infantile and adult mortality within a radius of seven miles of the city of Adelaide. It hopes that this commencement may prove useful hereafter when data have accumulated sufficiently upon which conclusions may be based.

With regard to public health, your Council hopes that the discussion on health officers initiated by the president (Mr. Hayward) with the result of the formation of a committee to inquire further into the matter, may result in some practical suggestions which will tend to make the relations between health officers and the Central Board more satisfactory.

Your Council can look back with satisfaction on the work that has been done during the past year, as showing the continued interest the members take in the Association.

The present depressed condition of the colony has had its effect on the membership of the Branch. Not less than six members have left for other parts. There has been one death. There have been seven new members elected, so that the members of the Branch have remained stationary, and continue at 71.

The receipts for the year amount to £164 15s. 7d.; the expenditure to £79 11s. 10d., leaving a balance of £86 3s. 9d. of receipts.

Your Council would remind the members that the Jubilee Exhibition will be held next year, and would suggest that some arrangements should be made both for receiving distinguished medical visitors, and also for ensuring a suitable display of medical and surgical apparatus, &c. As not only will the present Council have ceased to exist, but two other councils have been elected between now and then, it would suggest the desirability of appointing now a standing committee to make arrangements to superintend, and who shall be empowered to act with any Council that may be in existence at the time or before, which council shall be, *ex officio*, a portion of the committee. It was then proposed and carried that the suggestion of the Council

respecting a standing committee to make arrangements for the Jubilee Exhibition be followed. The following members were elected to form it, and to act in concert with any existing Council at the time :—Dr. Gardner, Mr. Hayward, and Dr. Stirling.

The retiring president, Mr. W. T. Hayward, M.R.C.S., read the following

PRESIDENTIAL ADDRESS.

GENTLEMEN,—

Twelve months ago, on a similar occasion to the present, we met in this room under the presidency of one, who by his genial and courteous manner had endeared himself to all of us—one short week afterwards many of us attended at the side of his grave to bid a sad farewell to our esteemed comrade. My first duty as his successor to the presidential chair was the painful one of moving a vote of condolence with his sorrowing widow, and in doing so, I expressed the opinion that in the ensuing meetings we should sadly miss his well-known face and cheery voice. How true that surmise has proved, you well know, but though gone from us, Dr. Chas. Gosse bequeathed us a legacy through his example. He was the first president who formally delivered a retiring address. I know that he was desirous that the custom should be continued. I consider that I should be acting unfairly to his memory should I, through any unwillingness on my part, do anything that might lead to the discontinuance of the practice, and when I consider who is to succeed me in my present position, I also feel that I might be the means of depriving our society of an intellectual treat that I know will be anticipated with pleasure. But, though the spirit may be very willing, the task is none of the lightest to one who is altogether unaccustomed to such kind of work. I am confronted with the initial difficulty, viz., to find a subject on which I can presume to address you. To give a *résumé* of our proceedings during the past year, after the report of the Council that you have just heard read, would simply be a case of a twice told tale. I have not the advantage of having a speciality in which I might hope to be able to afford information that might be novel to most of you, I am thrown back on general medicine, a subject with which many of you are better acquainted than I am myself. I must ask, then, your forbearance, while I say a few words on a matter that interests me a great deal, and which I believe will well repay our attention. I refer to "Septic Diseases and Antiseptic Remedies."

It seems only the other day that the "Germ" was simply the toy of biologists, a term on which rival scientists might weave intricate theories, but thanks to the labours of such men as Tyndall and Lester in England, Pasteur in France, and Koch in Germany, we are beginning to comprehend the mighty factor, the Germ, in the form of "Bacillus" or "Bacterium," "Micrococcus," "Spirilla," in the part it plays in the universal economy. Instead of being the interesting curiosity whose fitting place seemed to be the microscopic slide, we now know that in some form it is always with us in the air we breathe, the water we drink, and the earth we walk on, that it performs functions analogous and complementary to those of plants and animals, that without it nature would be unable to pursue the even tenor of its way, and what is especially important to us, as medical men, that it is the cause of many of the diseases we are called upon to combat. This being the case, it is all important that we should be well acquainted with its life history in general,

and its various forms. I do not propose this evening giving you a scientific lecture on Germs. I have not the knowledge to enable me to do so or the skill to impart it, even if I had it. I wish simply, as a practical medical man, engaged in general practice, to draw your attention to the bearings this potent element has to our healing art, and to show how a knowledge of the subject may be utilised in our every day life. But, before proceeding to the practical part of my paper, I think it would be well to sketch briefly and roughly some of the traits of the life history of some of these germs. Firstly, as to reproduction; they increase with stupendous rapidity; it has been calculated with regard to one or two varieties, that, grown on suitable soil and in a proper temperature, they double their numbers at least once in an hour, so that every individual produces 8,388,408 in 24 hours. Their mode of reproduction is chiefly by means of budding but in addition to this, some varieties are capable of producing spores. This is of extreme importance, owing to their resistant qualities, for, whereas ordinary germs are killed outright by moderate heat or cold, or by many chemical agencies, spores pass through these ordeals unscathed, moreover, they may remain quiescent for an almost unlimited period, and when suitable conditions for activity present themselves, they come up smiling as if nothing had happened, and pursue an active, though sometimes not useful career. This characteristic will, I think, account for the endemic appearance of infectious diseases, and for the reappearance of these diseases in houses which we imagine we have effectually disinfected. In relation to this part of the question, one of Tyndall's experiments when he was investigating the subject of spontaneous generation, is interesting. He found that, no matter how long he boiled a certain hay infusion, though he at the same time completely destroyed all trace of bacterial life, and effectually prevented an infection from outside sources; yet, in a day or two, new evidences of life appeared, but, by boiling the infusion for a minute, three days in succession, the liquid remained clear for an indefinite time, the reason for this being that, in his first experiments he had destroyed the bacteria, but the spores had resisted the prolonged heat, but in the second, that between the first and third boilings, the spores had developed into bacteria, and consequently became destroyable.

The life history of various germs is very interesting, and affords food for reflection, which may be practically utilised. It is found that different varieties require different media in order to flourish, also that the presence of a certain specimen effectually prevents the fructification of another; that the addition of certain materials will either lessen or prevent reproduction; as an example, take the case of the "Aspergillus niger." This belongs to the "Mucidinia" species, and is allied to the common mildew. It grows readily on many things, but, like other germs, has a favourite media in which it thrives to perfection. This, M. Raulin has found to consist of a mineral solution composed of water, 1500 grammes; sugar candy, 70grms.; tartaric acid, 4grms.; nitrate of ammonia, 4grms.; phosphate of ammonia, 0.6grm.; carbonate of potassium, 0.6grm.; carbonate of magnesia, 0.4grm.; sulphate of ammonia, 0.25grm.; sulphate of zinc, 0.07grm.; sulphate of iron, 0.07grm.; silicate of potassium, 0.07grm. Cultivated under proper conditions, the plant, after a few days, exhausts the nutritive liquid; the product weighs 25 grammes; but suppose in this liquid the potassium has been omitted, (mind you the amount was only 0.6), the pro-

duct would only weigh one gramme or only 1-25th of the full amount. If the ammonia is omitted, it will only reach 1-150th; if the phosphoric acid, 1-200th. This seems strange, but it is stranger still that, if the zinc be omitted from the solution, which only contains a 50,000th part, the crop of the plant will only produce a twelfth. These facts point to the extremely sensitive nature of the plant, but, perhaps, the negative aspect is more important, and I think more interesting from a practical point of view. If one-sixteen-hundred-thousandth of nitrate of silver be added to the nutritive liquid, the vegetation stops abruptly. It cannot even commence in a silver vase. It is affected in the same way by 1-50,000th of corrosive sublimate, by 1-240th of sulphate of copper. The withdrawal of the iron gives rise to similar effects, as does the withdrawal of the zinc, and the addition to it causes increased fertilities, not because the plant requires an increase of that mineral, but because its presence prevents the formation of a secretion that is inimical to its well-being.

As I said before, different germs like different media in which to flourish; for instance, Yeasts like lime, which the Aspergillus does not require, and the "Penicillium glaucum," which is very similar to the A-pergillus, and grows well in Raulin's liquid, is improved by the addition of a little gypsum.

I am indebted to Dr. Duclaux and Mr. Watson Cheyne for the above facts. I have taken them from papers written for the section of Hygiene at the recent Health Exhibition in London. I shall draw further from the same sources later on. I shall leave you, gentlemen, to draw your own deductions, and inferences from the same facts, and pass on to matters of more professional interest.

Micro-organisms are so numerous that it is almost difficult to say where they cannot be found, but there is one place where they ought not to be, viz., inside the human body proper, by that, I mean, inside the body as bounded externally by the skin, and internally by the alimentary canal; on the skin and in the canal they may be found normally, but when they pass these bounds and infest the blood and tissues, then a state of disease supervenes. Year by year we are gradually learning that in certain diseases certain micro-organisms are to be found, and it seems to me that it is only a matter of time when it will be demonstrated that a large proportion of the diseases to which flesh is heir, are due to these minute, yet powerful bodies, and I shall certainly not be incredulous if some observer asserts that the processes of inflammation may be ascribed to a similar cause. I notice that the late Dr. Hilton Fagge, in his recently published "Practice of Medicine," states that the evidence accumulated from various sources, "almost, if not quite, amounts to proof that the contagia are living organisms of exceedingly minute size." Should this prove correct, the nature and origin of a large class of diseases will be explained. Mr. Watson Cheyne says that the following are the chief steps required for the proof that a germ organism is the cause of a disease:—"Firstly, an organism of a definite form and with definite characteristics must always be found in the blood, or in the affected parts of the animal body. The blood or the affected parts containing these organisms, when inoculated into another animal of the same species, must produce the same disease. Treatment of the blood or the affected parts in such a manner as to destroy the micro-organisms present in them must also destroy their power of causing disease in another animal. When the diseased parts are inoculated on suitable soil outside the body, the micro-organisms grow, and can be indefinitely propagated on

similar soil. When, in this manner, the organisms have been separated from the remains of the animal substances in which they were embedded, their inoculation on a suitable animal must again produce the disease, the same organisms being found in the diseased parts." I think you will agree that these conditions are stringent enough, and that an experiment satisfying them must be deemed proved—several diseases have furnished this kind of proof. Among others, septicaemia, anthrax, glands, erysipelas, tubercle and pneumonia; other diseases, such as typhoid fever, ague, relapsing fever and cholera, though distinctive germs have been discovered, have been unable to meet the above requirements. The vibrio of septicaemia is well-known, and the bacillus of anthrax has also attained notoriety, but it is only quite recently we have learned that in erysipelas large numbers of minute micrococci are to be found at the spreading edge of the inflammatory process. Bacilli may be found in the cells of tubercle, and pneumonia is characterised by micrococci that assume a peculiar pin point formation at the place of infection. In typhoid fever short, thick, rod-shaped bacilli are found; in relapsing fever the germ belongs to the spirilla variety. Within the last year or so, we have heard a good deal of the "comma" bacillus of Koch, though many trustworthy observers doubt whether cholera can be fairly ascribed to it. Coming from diseases which affect the internal organs to those that manifest themselves externally, we have the well-known examples of "Mous" and "Ringworm." No doubt many other forms of skin disease might be traced to similar causes. Considering the matter from a clinical point of view, a good deal may be said in favour of the germ origin of disease. Using the theory as a working hypothesis many peculiarities arising in diseases, not usually considered zymotic, may be explained. Take, for instance, dysentery. This is not usually classed either as a contagious or infectious disease, and yet how often do we find at certain times and seasons it becoming almost epidemic, attacking several members of the same household at the same time or one after another. Take again pneumonia. I'm sure we must all of us, over and over again, have been called to see patients who have been suddenly seized with rigors or shiverings, suffering from extreme headache, dusky countenance, and a temperature of 103° to 105° , and have been unable to discover any local cause to account for the severe symptoms; but after a few days, a small patch of pneumonia has developed, which resolves in a few more days. Then there are other cases with the same initial symptoms, and the only local sign may be a small area where friction sounds may be heard on one day and are gone the next—this without subsequent effusion. I have known cases where I have found friction on one side of the chest one day, and on the next found it gone from there and present on the opposite side; these cases, however, frequently develop into what are apparently ordinary cases of pneumonia, pleurisy, or pleuro-pneumonia. A short time ago I was attending at a house on two cases of dysentery, of the kind I have alluded to, when another inmate was suddenly seized with very acute pericarditis; he was a middle-aged man who had never suffered from rheumatic fever, nor were any of his joints affected at this time. He was suffering intense pain over the region of the heart, dyspnoea and violent headache. His countenance was suffused with a dusky red hue, the temperature was 105° ; loud friction sounds were to be heard all over the precordial region. I gave him, frequently, repeated doses of salicylate of soda; the symptoms were almost immediately relieved; in two days no friction was to be heard; there was no evidence of effusion, temperature

and pulse had gone down to the normal; the third day he got up, much against my wish, but he experienced no ill effects from his temerity; he was only away from his work for one week. My attention was all the more directed to this case, irrespective of its unusual nature, because I had treated the two cases of dysentery in a similar manner, though not with the marked success as in his case, yet very satisfactorily. I have on several occasions noticed that I have been called upon to attend cases of dysentery in houses where I had shortly before attended cases of diphtheria or pleuro-pneumonia or *vise versa*, and where I have had reason to believe that bad drainage was the predisposing cause of both diseases. Using the germ theory as a working hypothesis, the existence of certain diseases in certain localities is easily explainable, and little difficulty will be experienced in accounting for the presence of malarial fevers, dengue, or even yellow fevers. I have long thought that the etiology of many diseases being ascribed to "taking cold" is, to say the least of it, very misleading. Take, for instance, the ordinary coryza; let one member of a household have the complaint, and the chances are that shortly after the remainder will exhibit symptoms. They surely have not all sat in a draught or got their feet wet. I think the occurrence is better explained on the theory that though the first member may have sustained a chill, and rendered him susceptible to some micro-organism, which, I dare say, is more or less always present, he has rendered himself a focus or breeding ground, and has thrown off an innumerable quantity, and the remaining members of the household, though able to withstand the presence of a limited number, succumb to the attacks of a regular army. Many similar examples might be adduced, but I think these are sufficient for my purpose. I propose to say a few words with the object of showing how the above facts and theories may be reduced to practical usefulness. Lister used to insist that it was necessary, in order to obtain good results, that his followers should not only adhere to his practice, but must believe in his theory. We all know what the result has been in the domain of surgery from the intelligent following out of that great man's views. When the history of the surgery of the 19th century is written, the brightest page will be that on which is recorded the work of Sir Joseph Lister. But, while surgery has been prompt to utilise the knowledge science has taught in relation to micro-organisms, medicine has, I fear, lagged woefully behind. Certainly, of late, more attention has been directed to it, and it is with a view of drawing the attention of our small circle to its importance, that I have chosen this subject to speak upon to-night. I propose to say a few words on the antiseptic treatment of a few diseases of which I have had personal experience.

I will commence by alluding to phthisis. As I before mentioned, in specific micro-organism the tubercle bacillus is found in the lungs of phthisical cases. My theory is that as there are media which favour the growth of certain germs, and others that will not support it, so there are persons whose lungs favour the development of the tubercle bacillus, and others that repel it; also, lungs that, under ordinary circumstances, are able to resist its attack which, under altered conditions, are unable to do so. This, I think, will account for the hereditary tendency of the disease. There are certain localities where the air abounds with micro-organisms, and others where it is comparatively free from them; put a man with a hereditary tendency to phthisis to live in the former, such as an overcrowded, low-lying part of a town, or let him work in an ill-ventilated workshop, and the chances

are that he will soon fall a victim to the disease; on the other hand, let him live an outdoor life on some breezy down, no matter how cold it is, and he will probably escape. The indications for proper prophylactic treatment thus become plain. But when the disease has actually developed, attention to these facts is still important. In the early stages of phthisis, I think the lungs are in a continual state of warfare with these outside enemies, and provided the odds are not too great against them, and the other organs of the body are kept in good working order, they may yet come off victors; the air in mid-ocean, on the Davos Platz, and the heights of the Cordilleres are almost free from micro-organisms. From long experience, the benefits arising from a long sea voyage, in certain cases, are well recognised. But while on this subject, I would like to protest against the absurdity and cruelty of sending phthisical cases on a voyage from England to Australia, in a crowded steamer, where the stuffy cabins and the aggregation of many passengers in a confined space, effectually counteract any benefit the inhalation of the ocean air is able to effect in the short space of a month or six weeks; from my experience on board these vessels, I regret to say that the practice is only too common, and is fraught with great misery. I cannot believe that the beneficial effects that undoubtedly result from residence at high altitudes is caused by the increased rarification of the air. It seems to me that such a factor alone would prove prejudicial, and it hardly seems rational to think that an atmosphere that necessitates a damaged lung to work at high pressure can do that lung any good. But that such residence is beneficial, I had good evidence some years ago when I was travelling between Peru and England. On board ship I made the acquaintance of a gentleman, a relative of the late Dr. Wilson Fox, who had resided for twelve months at Bogota and other places in the Andes at an altitude some 8000 to 12,000 feet above the level of the sea. Symptoms of phthisis had developed some ten years previously, and he had twice made the round voyage to Australia and back in the old "Great Britain," both times with considerable benefit to his health, but the symptoms continued to develop on his return to England. His physician, who was travelling with him, informed me that shortly after they had resided at Bogota, his patient's condition wonderfully improved. Before he left the neighbourhood he was able to perform most arduous feats of pedestrianism without any trouble. When I saw him there were no signs nor symptoms of phthisis. I may incidentally mention that this medical man told me that it was perfectly wonderful how, what we should consider mortal wounds, recovered in this climate without any surgical care whatever, and as one of the usual internecine wars was raging at the time, he had plenty of opportunity for observation. I think this latter fact supports my view—that the good results are due to the absence of micro-organisms, rather than to the tension of the atmosphere. But, gentlemen, I said that my remarks were to have a practical bearing, and I doubt whether you will consider the advice to send patients to Bogota or La Paz can come under that head, but though it is only under exceptional circumstances that we can do so, yet we have it in our power to adopt a modified course, by sending them to the Darling Downs, where, I believe, almost as good results might be obtained. To come to the antiseptic treatment of phthisis by means of drugs. Last year I read a paper in the *British Medical Journal*, by Dr. Shingleton Smith, of Bristol. In it he advised the use of Iodoform injected directly into the lung in the form of an etherial solution. Having two cases in the hospital that seemed to me suitable, I determined to try

this method. I did so for about a week, but by the end of that time, my patients had come to the conclusion that they preferred death to it, and positively declined a further trial. Consequently, I am unable to give an opinion as to the benefits likely to arise from this mode of treatment, except to say that it is very unpleasant. I have given the treatment of the inhalation of antiseptic drugs a very fair trial, and am bound to confess that it has not come up to my expectations; but I must nevertheless say that in many cases it has had a marked effect, both in lessening the cough and decreasing the expectoration, and in one case of incipient phthisis it has, I believe, kept the disease in a stationary condition for about twelve months. I have also found this treatment useful in cases of chronic bronchitis. The drugs I have employed have been carbolic acid, creosote, thymol, eucalyptol, by means of MacKenzie's naso-oral inhaler.

Typhoid fever is a disease that, up to the present time, seems to have defied all, what one may call, direct treatment. Physicians seem content to be satisfied with a system of masterly inactivity. That such should be the case does not, I think, redound to our credit, and I do not believe that such a position will be maintained for many years. During the past year I have treated most of my hospital cases with some form of antiseptic drugs, and though I have not had any startling result so far, my experience will lead me to continue that mode of treatment, for I certainly think that the cases in which I have pursued it have done better than those in which I have adopted the routine method. My first experiment in this line was with hydrarg. perchlor. in a young girl in whom the initial symptoms were very severe. In four days time I found that I had succeeded in salivating my patient, and that the temperature remained at about 104°. I consequently desisted, and substituted aq. camph. for the more powerful remedy. The temperature ran down rapidly, and the girl made an excellent recovery in a comparatively short time. Whether the primary heroic treatment was a factor in the subsequent good result I am unable to say, but I was not sufficiently satisfied to continue further experiments with the same drug. In two cases in which I used hyposulphite of soda for the patients who, when first admitted, were very bad, the disease rapidly assumed a more easy form, and though the fever ran the usual course, I had no further anxiety with them, and thus made a good recovery. In a fair number of cases I have used carbolic acid in from one to two drop doses every four hours, and without exception these cases have done well, and I can certainly recommend this mode of treatment. My results with Salicine have not been very satisfactory. I have found that though in the early stages of the disease it has had the effect of greatly relieving the severe headache and the pains in the limbs and back, it has not proved of much service afterwards. In my private practice I have lately attended two cases exhibiting the prodromal symptoms of typhoid fever, which almost immediately subsided under the influence of salicylate of soda, and the patients resumed their ordinary avocations, but after the lapse of three weeks the disease made its appearance again, and ran its usual course. While granting that none of the above methods can be considered successful in the light in which I am treating the subject, yet I would submit that they give indications that a better result may very probably be obtained by treatment under similar lines.

Erysipelas is a disease in which characteristic micrococci are present in large numbers, and is consequently one in which antiseptic treatment should be useful. The brief notes of two cases will, I think,

prove that it is so. M. D., at. 36, female. Jan. 2nd, seized with a rigor, headache and pains in limbs; next day face began to swell. Jan. 4th, when seen by me she was suffering from intense headache, had been delirious during night. Erysipelatous swelling of face, forehead and ears; scalp tumid and very painful; temp., 105°; pulse, 120; ordered saline purge, face to be painted with collodion; 10 grs. of salicylate of soda every two hours. Jan. 5th, better night, pain easier, swelling less tense; temp., 101°; pulse, 100. Jan. 6th, good night, no pain, temp. and pulse normal, tongue cleaning. Jan. 8th, quite well, with exception of scaling of face. G. H., at 26. Erysipelas of head and face, has been under treatment (T. iron perch.) for three days; says she is no better, headache intense, skin of face and scalp much swollen and painful, tongue foul; temp. 104°; pulse, 120; ordered soda salicyl. gr. x every two hours. In four days patient was out in her kitchen cooking when I made my visit. She had no relapse.

Whether "pneumonia" is simply a local inflammatory disease of the lungs, or a local manifestation of a systemic disease is too large a question to be discussed at the tail end of an address, so I will only say that holding the latter view, and moreover considering that in a large majority of cases it is due to the presence of micro-organisms, I have adopted the principle of treating it by antiseptics. The following case, bearing as it does both on the etiology and treatment of the disease is, I think, interesting. M. P., at. 26. Oct. 9, 1885. Felt quite well yesterday. This morning came out of hot bakehouse, and cleaned out a tank which contained two or three inches of badly smelling mud; a quarter of an hour afterwards felt a violent headache; feet and head hot; aching throughout limbs; went to bed and slept for two hours, and awakened with feeling of chilliness, and was light-headed; cough supervened, expectorated frothy mucus at first, afterwards two or three mouthfuls of blood, followed by bloody mucus. 1 p.m., pulse, 100; temp., 103°; headache, coated tongue, bowels open, sharp pain in left side on movement, dullness on percussion over left posterior scapular region, tubular breathing, vocal resonance plus, vocal fremitus minus, no crepitus. Ordered soda salicyl. gr. x every two hours; cold compresses to affected side. Oct. 10th. Feels much better, passed a good night, no headache, breathing easier, cough not so troublesome, bloodstained expectoration, tongue cleaner, bowels rather loose, area of dullness well defined, physical signs as of yesterday, except that there is fine crepitus on coughing or deep inspiration. 11 p.m., acute pleuritic pains supervened. Morph. mur. gr. $\frac{1}{2}$, 3 horis. Oct 11. Pain easier; temp. 102.5°; pulse, 100; pneumonic crepitus at base of left lung; dry friction sub-anteriorly, also at base of right lung. October 12th. Better night, pains returned last evening, relieved by morphia pill, breathing much easier; temp., 98.4°; pulse, 88; slight traces of friction in left sub-axillary and right dorsal region, tubular breathing, &c., in left dorsal, no crepitus. Oct. 13th. Very much better, has eaten a good dinner, pain very slight, breathing normal, tongue cleaner, bowels open; temp., 98°; pulse, 84; pneumonic signs resolving; decreased dose of soda salicyl. Oct. 14th. Sleeps and eats well, pleuritic pain on drawing deep breath; temp., 99.1°; pulse, 84; pleuritic signs rather more marked, increased soda salicyl. Oct. 17th. Got up yesterday and to-day, feels very much better; temp., 98.4°; pulse, 84; physical signs clearing up. From this time made an uninterrupted recovery. I have had several similar cases to the above attended with more or less similar results, but in more than one I found that the reduction of the

amount of the saline before convalescence was thoroughly established, meant the return of the pneumonic or pleuritic symptoms and signs; as in acute rheumatism, so in these diseases, it is necessary to continue the use of the drug for some time after the symptoms have subsided.

In the discussion on diphtheria that we had at the early part of the session, I gave my opinion as to the nature and treatment of the disease. Subsequent cases have only confirmed me as to the beneficial action of soda salicylate in this disease, and I may add that I find it equally potent in what may be called septic sore throats, and to a less extent in cases of acute tonsillitis.

I am afraid that I am wearying you, but I should like to draw your attention to this mode of treatment in two other diseases, before I conclude. I allude to dysentery and puerperal septicæmia. Dysentery, or, as I should prefer to term it, croupous inflammation of the lower bowel, is far from uncommon in this colony, and at times it proves most obstinate. It is usually ushered in with more or less severe febrile symptoms, succeeded before long by the passage of blood-stained fibrinous matter, often at intervals of every ten minutes or even less, accompanied with severe pain and tenesmus. It not uncommonly happens that more than one member of a family is attacked, and I have known it run through a household. I have little doubt in my own mind that this is but another form of septic disease, very probably propagated in a similar manner to typhoid fever. I must resist the temptation to enter more fully into the matter, for I have only introduced it to point out that it is generally easily amenable to the influence of frequently repeated doses of salicylate of soda, especially if combined with fair doses of scilate of morphia.

Those of us who have had much experience in midwifery practice, know only too well that often in a case that seems to be doing well, about the third day after delivery, the patient is seized with a rigor. The face is flushed, the lochia stopped, the temperature runs up to 104° or 105°, and the pulse to 120. There is severe headache, aching in the limbs, dry skin, or at other times rather profuse sweating, accompanied at times with some abdominal pains, and in others without any local signs. These symptoms are often produced by the secretion becoming pent up in the uterus, and will subside by it being relieved either by nature, or art in the shape of the intra-uterine douche; but this is not always the case, for this may be caused by septic absorption, which I believe is also a factor in the first class as well. We have rarely a case of puerperal septicæmia, and I know of no affection that so readily succumbs to treatment. A mixture of glycerine and carbolic acid, M.V., combined with lime water, has a most marvellous effect, and if any gentleman doubts the value of antiseptic remedies, I would strongly urge him to give this method a trial in his next case, and I will vouch for it that he will modify his opinion.

Gentlemen, I have brought this subject before you very imperfectly, and with a considerable amount of prolixity, but I have endeavoured to show that micro-organisms, small as they are, are very potent; that they differ greatly in character and habitat, and are materially influenced by their surrounding media; that they play a very important part in disease; and that by recognising their presence and power, they may be combatted with a certain class of drugs. Time and further experience will enable us to deal more exactly with them; scientific observation will no doubt help us; meanwhile, if we have only the rule of thumb to guide us, it behoves us all to make the best use of it we can, feeling sure that, sooner or later, more accurate

modes will be evolved thereby. I have purposely omitted to mention the cognate labours of that great French savant, Pasteur. To have ventured into the subject would have required more time than is allotted to me this evening, and, in fact, his researches are beyond the scope of my remarks. His work opens out a vista that taxes the powers of the imagination. I have only endeavoured to be matter of fact. I feel that the theme I have chosen is far beyond my powers to illustrate. I must ask you to accept what I have said as an exposition of how this subject affects the thoughts of a general practitioner in that domain in which it is our pride and privilege to labour.

Before I resign the presidential chair to my esteemed friend and colleague, Dr. Verco, I trust you will allow me to return you my sincere and hearty thanks, firstly, for electing me your president, and, secondly, for the kind manner in which you have assisted and supported me during my term of office. An honour bestowed by one's professional brethren must always be doubly valued by a professional man, and it will always be a source of pride to me to remember that I have held the position. No one knows better than I that my attaining it was due more to your kindly feelings towards me than to any professional merit of my own. I must further trench on those feelings by asking you to look leniently on the imperfect manner in which I have performed the duties of the post from which I now retire.

Mr. Hayward then left the chair, which was taken by the president elect (Dr. Verco). A unanimous vote of thanks was accorded to Mr. Hayward for his interesting address.

The following officers were elected for the ensuing year :—Dr. Davies Thomas, vice-president; Mr. Corbin, hon. treasurer; Mr. Cleland, hon. secretary; Mr. Clindening, Dr. Gardner, and Mr. Hayward, members of council.

SANITARY SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

MONTHLY MEETING,

Held at the Society's House, Elizabeth-street, Sydney, on 14th September. Mr. Kyngdon occupied the chair, and there was a fair attendance. An interesting paper was read by Dr. R. E. Roth, on "The rational construction of chairs and school desks." The paper was illustrated by diagrams showing the back and shoulders under favourable and unfavourable sitting and writing positions. Models of chairs and desks were also exhibited. The paper treated on the proper shape of the chair back, and showed how curvature of the spine and other diseases were caused by a faulty construction, and the great importance of adapting the curvature of the chair to the shape of the spine was fully explained. In ordinary chairs, Dr. Roth said, the lever rail was wrongfully made—concave instead of convex, and in consequence no support was afforded to the spinal column. He thought that, with regard to school children, the importance of the subject had been greatly neglected, especially amongst girls, in whom the bad effects were not counteracted by physical exercise. An improved office-stool was also exhibited, provided with a support to the back. Votes of thanks were accorded to Dr. Roth and the chairman, and the meeting terminated shortly afterwards.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 58th General Meeting of the Branch was held at the Royal Society's House, Sydney, on Friday, 10th September, 1886. Present—Dr. Knaggs (President), in the chair; Drs. Clubbe, Fiaschi, Hoff, O'Reilly, Brady, Martin, Quaife, Marshall, Bowker, Hanks, Crago, Lovell, West, Roth, Faithfull, Wright, and Chambers.

Visitors—Drs. Evans and P. Sydney Jones.

The minutes of the previous meeting were read and confirmed.

Dr. Clubbe read some notes on a case of thyrotomy. The patient was exhibited.

Dr. Clubbe also read some notes on a case of multiple bony growth in a child. The patient was exhibited.

Dr. HOFF said with regard to the first case it was a pity the operation had not been successful. Cocaine was not much use in this case, as its effects did not go deep enough to be of use. The operation was exceedingly difficult in a child so young as this patient.

Mr. HANKINS said in the last edition of Holmes' Surgery a similar case to the second one related by Dr. Clubbe was given, when an operation was performed and much relief afforded to the patient; other growths were treated to a long course of blistering, and some of them disappeared.

Dr. Martin exhibited a larynx showing papillomatous growth.

Dr. Crago read a paper on "Tracheotomy in Croup and Diphtheria, with Notes of Five Cases," which will be published in our next issue.

Dr. LOVELL said he must congratulate Dr. Crago on the successful result of his operations. He (Dr. Lovell) had not been so fortunate, having performed the operation seven times, only three of the operations had been successful. Dr. Crago kept the tube in a much longer time than is generally the case, sometimes as long as three weeks. He (Dr. Lovell) had never kept it in longer than nine days. He quite agrees with Dr. Crago that the operation should always be performed if the parents will give their consent.

Dr. FIASCHI said he had listened with great interest to Dr. Crago's paper, but had failed to find wherein his success lay. He (Dr. Fiaschi) had never before heard of four successful cases out of five. He thought the size of the tubes used by Dr. Crago had something to do with the matter.

After a few remarks by the President and Dr. Quaife,

Dr. CRAGO said he thanked the members for the discussion which had taken place. Very few children under two years of age recover from the disease. He (Dr. Crago) had kept the tubes in longer than is usual, but he thought with no bad effect. Mr. Holmes in his work on surgery lays great stress on using large tubes and an early operation.

The President announced the death of Dr. Bestic.

Dr. HANKINS proposed, and Dr. O'Reilly seconded, "That a letter of condolence be sent to Mrs. Bestic." Carried.

The President read a letter from Dr. Murray Oram, apologising for his non-attendance, and stating that he quite agreed with the action taken.

Dr. HANKINS proposed "That a committee be appointed to draw up a report to be submitted to the Government and the Marine Board relating to the necessity for normal acuteness of vision and good colour perception in officers and seamen of the mercantile marine, and that the following gentlemen form the committee :—Drs. Evans, Maher, Oram, Knaggs, Roth, Fiaschi, Quaife, Brady, and the mover." Seconded by Dr. Lovell, and carried unanimously.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, OCTOBER 15, 1886.

EDITORIALS.

"DAIRIES SUPERVISION ACT."

THE bill for this purpose, which was introduced by the Honorable C. K. Mackellar, M.B., as the Representative of the Government in the Legislative Council of New South Wales, was passed by that Chamber on July 7, by the Legislative Assembly on Sept. 14, and having received the assent of the Governor, has become an Act of Parliament.

It is now only in force in the Metropolitan Police District, which includes Sydney and its suburbs, but the Governor may by proclamations in the *Gazette* extend its provisions to other parts of the colony.

This Act is really a section of the Health Bill introduced into the late Parliament by the Stuart Government, and it is much to be regretted that this greatly-needed measure was not reintroduced and passed in its entirety during the present session. However, the demoralized state of the Assembly and the powerlessness in that Chamber of the Government for good have made this impracticable, and the citizens of Sydney have much to be thankful for that in default of the whole they have got such a necessary and useful part.

It provides that within three months from the passing of the Act every person engaged in the supply of milk shall apply to be registered, and that he shall affix to his premises and to any vehicle used for the purpose, his name and the fact that he is so registered.

The local authorities are required to inspect all dairies at such times as may be fixed by the regulations under the Act, and are required to make a report of their proceedings under the Act to the Health Board in January of each year.

The local authorities may at all reasonable times enter all dairies or milk stores for the purpose of inspecting them, their utensils, and water supply, and may take away samples of milk or water for examination. They can require all dairymen or milk vendors to maintain their premises in a sanitary state; may with the consent of the Board of Health, require them to close any source of water supply likely to be detrimental to health; and may refuse to register, or cancel the registration of, any such persons whose premises are in so unsanitary condition as to render the milk liable to contamination. On the appearance of any infectious disease in the dairy premises or milk store, the occupier is required, in the city and suburbs of Sydney, to report the fact to the officer in charge of the nearest police station or to the Secretary of the Board of Health, and the medical practitioner attending the case is also required to report it to the same authority. It provides that if in the opinion of two medical practitioners the spread of any infectious disease is attributable to the milk supplied by any milk vendor, he may be required to furnish a list of his customers. Persons suffering from infectious disease, or having been recently exposed to infection, are not to be permitted to take part in any dairy operations. Proper rooms are required to be provided for the storage of milk, and no milk is allowed to be stored in any sleeping or living room, nor is any milk the product of a diseased animal, or which has been exposed to infection from any person suffering from an infectious disease, allowed to be sold. The Governor, on the recommendation of the Board of Health, is also, as quickly as possible, to declare what are infectious diseases for the purposes of this Act, and may from time to time alter or amend such declaration as may be required. Penalties are provided by section 11 for any breach of the Act, such penalty in each case not to exceed £20. The Act is a practicable measure, and cannot fail to be a protection and safeguard to the public health. Knowing as we all do, the dirty and neglected state of many of the premises from which milk is supplied, we cannot but congratulate the Health authorities on their success in inducing the Government to bring forward, and Parliament to pass, so useful a measure.

The glaring necessity for it was shown by the now notorious outbreak of enteric fever at the commencement of this year in the district of Leichhardt which was traced by the able enquiries of Mr. Ashburton Thompson to the terribly contaminated water supply of a dairy in that borough, and this, no doubt, insured the passage of the Act.

PROPOSED MEDICAL CONGRESS IN SOUTH AUSTRALIA.

THE action of the South Australian Branch of the British Medical Association in initiating a movement for the holding of a Medical Congress in Adelaide during the spring of next year is worthy of all praise. The period at which it is to be held is fixed at about the time of the opening of the Jubilee Exhibition to be held in that city in 1887, and this will, doubtless, add to the interest of the affair. A meeting of representatives of the whole medical profession of Australasia cannot fail to be of advantage, not only to our own body but to the people generally. Our surroundings are so different from those of older countries that a comparison of experiences by observant men will lead to discussion which must result in good. It will keep up that feeling of brotherhood which should always exist amongst medical men of all countries, and which is the more essential when they belong to colonies the offspring of one great empire. We hope that our readers, and these include all the leading men of Australasia, will not lose sight of the fact that the credit of medicine on this side of the world will be in a great measure bound up with the success of this the first Medical Congress held here, and that it is the bounden duty of us all to aid the movement with our utmost ability. Good papers should be written for choice on subjects peculiar to our practice at the Antipodes, so that the proceedings will possess a novelty which will excite more attention in the older countries than if they were written on matters common to themselves. It may also be the stepping stone to the formation of an Australasian Medical Association, an institution which we think would be of infinite advantage and more suited to our circumstances than the existing connection with an association at the opposite side of the world.

Dr. Poulton, of Adelaide, is the Hon. Secretary to the Congress Committee, and he will be happy to furnish particulars to any gentleman wanting information.

PRIVATE LYING-IN ESTABLISHMENTS.

ATTENTION has recently been called to the number of houses in Melbourne kept by unauthorised persons for the purposes of accommodating women, in the majority of cases unmarried, during their confinement. This is a glaring evil which has been rampant in that city for a long time, and it has without doubt, in very many cases, furnished facilities for the undetected criminal destruction of unwell

come offspring. Now that the particulars have been published, proper consideration has been given to the matter, and regulations have been framed under which alone such houses can for the future be conducted in that city. A medical man is but rarely called in to these places, so that the aid so often given by our profession in the interests of justice for the detection of crimes against life is very rarely possible. In Sydney the same thing is common, and there are even greater facilities for the nefarious calling than even in Melbourne. There being no law in any way to regulate the practice of medicine here, many unscrupulous, unqualified practitioners aid in the matter, and as their certificates as to the cause of death are received by the registrars as all sufficient, an easy means is at hand for the concealment of crime.

Evidence was recently given before the Committee of the Legislative Council of New South Wales appointed to enquire into the Registration of Births, Deaths, and Marriages, by a most intelligent and trustworthy witness that he had, in the course of his duty, come across many such houses, and in some found there was accommodation in each for twelve or even more parturient women, and he knows that births and deaths occur in these places which are not reported. He says : " Boxes or coffins go to the place late at night, and no one knows anything about them." The law does not require that still births should be registered, and this alone may be made a means of concealment. The same witness said : " I have heard an undertaker say that he could dispose of as many bodies as he liked without anyone knowing anything about it."

With such a state of things as this evidence shows, can it be doubted that even a worse state of things exists unnoticed by the authorities in Sydney than that which has aroused public indignation in Melbourne.

A NEW AUSTRALIAN LOCAL ANÆSTHETIC.

In this number we publish an interesting paper on a new local anæsthetic by Dr. Reid, of Port Germein (S.A.). It is an alkaloid which he has derived from *Euphorbia Drunmondi*, a plant which grows plentifully in the neighbourhood of that place. He has given it the name of "Druamine." The report which he gives of its action is most interesting, and it appears likely to become a very valuable therapeutic agent. Extended enquiry is advisable, and it is to be hoped that other practitioners will take this matter up and, after experiment, give their experiences of the qualities of the new alkaloid. Independently of

the interest attached to the effects of this new remedial agent, Dr. Reid has done good service in calling attention, by his example, to the wide field which exists in our indigenous flora for extended experimental enquiry. There are, doubtless, numerous plants peculiar to this continent which have valuable therapeutic properties, and which only require systematic research to become known as highly valuable medicinal agents.

COPIES of a circular which has been issued by the 'Australian Mutual Prudential and Medical Assurance Society,' recently established in Sydney, have been forwarded to us by several members of the profession in New South Wales. This society is apparently a combined Assurance and Sick Club Association which is ambitious of securing members all over the colony. The remuneration it offers to medical men is quite inadequate, and we can only hope that no practitioner with any self-respect will accept engagement by it.

[CONTRIBUTED.]

THE CARE AND TREATMENT OF THE INSANE.

THE institutions for the care and treatment of the insane may be roughly classified, as we have seen in previous articles, into three divisions, corresponding with the progress of the lunatic from a recent stage through the various steps leading to an unfavourable termination, namely—the hospital for recent or curable cases, the asylum for those requiring a longer course of treatment, and that for incurables. In accordance with a more hopeful view, however, a different course would have to be taken by the more fortunate among the insane. If a case run a favourable course in the hospital for the observation and treatment of recent admissions, the convalescent could not always be immediately returned to his home with safety. While a further stay in the hospital might be prejudicial or unproductive of benefit to the patient, the too sudden change from the seclusion of his retreat to the outer world would be liable to cause an unfavourable reaction in the patient's mind, to prevent the cure being completed, or to produce a relapse. Consequently, a short period intermediate between the systematic treatment of the patient in the hospital and his final discharge, should be spent in some sort of convalescent institution, where he would be brought into contact with healthy conditions of life, in the

form of occupation, amusement, and the society of sane people. Such institutions would be most favourably placed, for the majority of convalescents, in a retired situation in the country, where a system of boarding-out under proper supervision could be carried on. It is obvious that many patients, requiring that the attention and treatment that had brought them to a convalescent stage should not be abruptly broken off, after their removal from the hospital, ought not to be removed far from the latter, so that the superintendent might be able to visit and direct the treatment to a certain extent, when it may be desirable to do so. Long journeys would be obviated by such an arrangement, and the supervision of the same medical attendant would make relapse less likely; while if such did occur, the shortness of the journey back to the hospital or asylum would facilitate immediate treatment. Cottages situated on farms would doubtless offer the most favourable conditions for recovery, especially for those in whom the general health was bad; but workshops of different sorts would suit many cases just as well, and could be made to contribute towards the cost of the lunacy system. As a large number of the chronic insane now in the asylums could be, with advantage to all, boarded out, and their labour made a source of profit, workshops could be the more easily kept up, and farm labour provided all the year round, though removals from recovery would be constantly taking place. The chronic insane would feel the benefit of such arrangements as well as the curable, though wanting the prospect of complete recovery. The asylum would be to them a home, instead of a prison, from which they would go to their work outside, seeing fresh faces and forming new friendships while at work, and return to the asylum in the evening.

(To be continued in next issue.)

LETTER TO THE EDITOR.

MEDICAL ETIQUETTE.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—Would you kindly give me your opinion on the following case?

A holds the appointment of Medical Officer to the local hospital. B. is informed by a member of committee that they desire to change their Medical Officer, and is asked if he would accept the post if offered to him. At the end of the arrangements, B was asked what salary he would expect, and he agrees to accept £130, the former salary having been £150 per annum.

A had been dismissed a short time previous to this, and applications advertised for at a reduced salary.

It was mainly for reasons apart from the question of salary that the change was made; and at a general

meeting of subscribers the action of the committee was confirmed by a large majority.

Was B's conduct contrary to the rules of professional etiquette in accepting the appointment?

I remain, &c.,
ENQUIRER.

[THIS is apparently the same case which was submitted by another correspondent, who also signed himself "Enquirer," and whose letter was published, with our comments, in the August number. There appears to be but little difference in the facts as related. In the first B is said to have tendered his services to the Hospital Committee at a reduced salary; in the second it is stated that, prior to the termination of A's connection with the Institution, an arrangement had been made between the Committee and B for the latter to take the appointment—the whole matter being "cut and dried" behind A's back. B, if not offering to do the work at the lower salary, submits to the reduction without protest. B should have waited until the Committee advertised for a new Medical Officer, when, of course, the appointment would have been open to him, as to all other qualified practitioners. We see no reason to modify the force of our criticism, as given on the case submitted to us in August.—ED. A.M.G.]

THE MONTH.

NEW SOUTH WALES.

In the Legislative Assembly, on September 28, Dr. Tarrant moved the third reading of the Medical Practitioner's Bill, and it was carried without division after an explanation from the mover. The bill was then passed and ordered to be sent to the Upper House.

In the Sydney District Court, on September 22, John A. Guilfoyle, of Temple Court, Sydney, sued Dr. L Guyenot to recover the amount of two promissory notes, with interest thereon, in all £20 17s. 6d. Defendant's case was that in consideration of his signing promissory notes for £40, plaintiff promised to procure defendant an appointment as travelling Medical Referee to an insurance society, and guaranteed that he should be paid a salary at the weekly rate of £7 7s, defendant to pay his own expenses. The promissory notes sued upon were obtained on the representation of the plaintiff as stated, but the defendant, who had paid two of the promissory notes amounting to £20, asserted that he had received no consideration for making them, and was not indebted as alleged. Plaintiff obtained a verdict for the amount claimed. Mr. Bruck gave evidence as an expert, stating that his fee for obtaining such an appointment, which could easily be got at any time, never exceeded one guinea.

THE late Mr. Thomas Walker, of Concord, near Sydney, in his will directs his trustees to distribute among the charitable institutions of New South Wales £20,000 in such proportions as they may determine, and he bequeaths £100,000 for the building and maintenance of a hospital for convalescents to be built upon a site of about 20 or 30 acres devised by the testator for that purpose at Rocky Point on the Parramatta River.

At a recent meeting of the Directors of the Sydney Hospital, Dr. W. R. Clay was appointed Resident Medical Officer in the place of Dr. Terrey, resigned, and Dr. Woodward was elected to fill the vacancy on the honorary surgical staff caused by the resignation of Dr. Craig Dixson.

IN the Kiama Temperance Hall, on September 22, a public meeting was held with the object of erecting a memorial to the late Dr. Lacey. The matter was taken up warmly, and a sum of £30 was subscribed at the meeting.

DR. TABRANT, M.P., laid the foundation stone of the Kiama Cottage Hospital on September 22. Contributions amounting to nearly £80 were laid upon the stone. All visitors highly eulogised the site as being admirably adapted to the object in view.

SOME months ago, J. H. Mathews, a chemist at Albury, committed an unjustifiable assault upon Dr. Cleaver Woods of the same place. Mr. Mathews has now tendered to Dr. Woods an unqualified apology, stating at the same time that he was wrongly informed as to the action taken by Dr. Woods as a member of committee of the late Albury Bachelors' Ball, and that while under an erroneous impression as to the facts of the case he acted as he did. In thus expressing his sincere regret for what had occurred, Mr. Mathews forwarded his cheque for £275, which Dr. Woods distributed as follows:—To the Albury Hospital £100, to the Albury Ladies' Benevolent Society, £25, and to his solicitor £150 for legal expenses incurred by taking proceedings against Mr. Mathews.

DR. J. A. BEATTIE, late Senior Surgeon in the N.S.W. Immigration Service, has succeeded Dr. W. E. Strong as Surgeon Superintendent of the Government Asylum for the Infirm and Destitute at Liverpool.

DR. F. H. BONNEFIN, a new arrival, has commenced practice at Newcastle.

DR. E. DRUMMOND has left Balmain.

DR. A. FORBES, late of the Tweed River, and formerly of Walgett, has just returned to the Colony from his trip to England.

DR. GOVETT, of Randwick, has removed to Norton street, Leichhardt, near Sydney.

DR. G. C. JACKSON, late of South Australia, has commenced practice at Dubbo.

DR. C. G. LEACOCK, late of Lambton, has succeeded to the practice of Dr. Geo. Goode at Camden.

DR. W. W. McGWIRE has commenced practice at Cundletown, on the Manning River, in an agricultural district, 200 miles N.E. of Sydney.

DR. W. H. ROGERS, of Stockton, has removed to Greta, a coal-mining township not far from Newcastle.

DR. C. TERREY, late Resident Surgeon of the Sydney Hospital, has succeeded to the practice of the late Dr. Lacey at Kiama.

DR. E. S. TRESIDDER, late of Coonamble, has removed to Brewarrina, in a pastoral district, 527 miles N.W. of Sydney. Dr. Tresidder has been appointed Surgeon of the local hospital.

WE have been requested to call the attention of our readers to the advertisement in this issue of Mrs. Leslie and Miss Cooms, Trained Medical and Surgical Nurses, and Mrs. McCall, Experienced Ladies' Nurse, of Corben Terrace, 363 Riley street, Surry Hills, who offer their services to the profession in all cases where the assistance of trained nurses is required.

NEW ZEALAND.

DR. WALTER DUNN, of Wellington, has removed to Roxburgh, on the Molyneux River, in a gold-mining and grazing district, 100 miles W. of Dunedin.

DR. A. A. COTTER, has commenced practice at Gore, in an agricultural and pastoral district, 99 miles S.W. of Dunedin.

DR. J. MCBREARTY, of Outram, has removed to Kumara, on the West Coast, 18 miles N. of Hokitika.

QUEENSLAND.

DR. AHEARNE, of Townsville, the representative of the North Queensland Separation League, was banqueted at the Criterion, London, on September 21, prior to his departure for Australia.

DR. GUIDO THON, of Rockhampton, has resigned his appointment as a Surgeon in the Queensland Defence Force.

DR. P. H. NUTTING, late of Elsternwick, near Melbourne, has commenced practice at Townsville.

GEORGE WILLIAM MACARTNEY, L.A.H. Dubl., 1879, L. et L. Mid. R.C.P. et R.C.S. Edin., 1881, Government Medical and Health Officer at Townsville, died on Tuesday night, September 28, by taking an overdose of a sleeping draught. He went to bed at 5 p.m. and was discovered to be in a critical state at 9.30 p.m.; he died shortly afterwards. The deceased gentleman was formerly in the Queensland Immigration Service; he also held for a short time the appointment of Medical Officer to the Ipswich Hospital, and to the Burke District Hospital at Normanton.

SOUTH AUSTRALIA.

THE Royal Colleges of Surgeons and Physicians, Lond., have decided to recognise certificates of attendance at the lectures on anatomy, physiology, and chemistry delivered at the Adelaide University.

DR. B. POULTON, late Senior Resident Medical Officer at the Adelaide Hospital, has commenced practice at 50 North Terrace, Adelaide; Dr. Poulton has also been elected honorary assistant-surgeon to that institution.

FREDERICK JAMES BOLLEN, M.R.C.S. Eng. et L.R.C.P. Lond., 1882, late of Port Adelaide, died at Penzance, England, on August 18.

VICTORIA.

AT the meeting of the council of the University of Melbourne, held on September 13, nearly all the time was devoted to the re-consideration of the subject of the appointment of clinical lecturers at the Melbourne Hospital. The council, at its immediately preceding meeting, resolved to appoint four clinical lecturers, and to pay them at the rate of £125 per annum each up to the end of December next. The sum of £500 per annum is, it may be stated, available for the remuneration of clinical lecturers. It was likewise resolved to ask the faculty of medicine to invite applications for the four lectureships, and to report on them to the council. At the above meeting a report was brought up from the faculty, adhering to a recommendation they had previously made, that only two clinical lecturers be appointed, one on the medical and the other on the surgical side of the hospital. It was ultimately resolved to make a temporary arrangement by which four clinical lecturers—two on the medical and two on the surgical side of the hospital—should be appointed, and should be paid up to the end of December at the rate of £250 per annum each. The lectureships were then conferred on Dr. Williams and Dr. Fulton (physicians), and Mr. Fitzgerald and Mr. Girdlestone (surgeons). At the same meeting, a letter was read from Professor Halford expressing a hope that the council would not subject him to any more "petty annoyances." Professor

Halford had engaged an assistant without the authority of the council. This body subsequently authorised the payment of the assistant, but from a date subsequent to that on which he was engaged by the professor. The refusal to ratify the professor's action aroused his anger, and the letter that he addressed to the council was designated by members of that body as "childish" and "impertinent." It was decided not to receive the epistle.

AT a meeting of the council of the Melbourne University, held on September 27, a claim made by Professor Allen was taken into consideration. Dr. Allen was appointed lecturer in anatomy and pathology in December, 1881, and the duties then prescribed for him included those of demonstrator of morbid anatomy at the Melbourne Hospital. The hospital committee also paid him a salary of £150 a year as pathologist. About two years later Dr. Allen was appointed professor in the subjects mentioned, and shortly afterwards he secured the removal of a valuable pathological collection from the Hospital to the University. The Hospital committee now reduced the salary of their pathologist to £50 a year, and the reduction was attributed directly to the removal of the pathological collection. It was thus contended that Professor Allen had been made to sacrifice £100 a year through doing a valuable service to the University. Mr. Andrew Harper moved that Professor Allen should be recouped at the rate of £100 per annum since the 1st January, 1884. To this objection was taken, on the ground that the work of demonstrator of morbid anatomy was included in the duties of professor of anatomy and pathology, and that it was covered by the salary attaching to that chair. Mr. Justice Webb moved an amendment to the effect that Professor Allen had been already paid for the services for which he now claimed remuneration, and after considerable discussion the amendment was carried by seven votes to five.

THE Central Board of Health held a special private meeting on October 1, to consider a confidential report by the police on private hospitals, which are now numerous in the city and suburbs, but which are under no systematic supervision. The board adopted a series of recommendations to the Chief Secretary for bringing these hospitals under legal control and Government supervision.

THE Central Board of Health has adopted as a basis in quarantining vessels for small-pox in future that 15 days from the convalescence of the last small-pox patient should be regarded as the "clean" period, or 21 days when the passengers did not undergo revaccination.

DR. BLAIR, chairman of the medical staff of the Alfred Hospital, has written to the managers of that institution intimating that it was the intention of the staff to hold a dinner in connection with the hospital, and asked for the co-operation and concurrence of the managers. The latter have unanimously resolved to accept the suggestion, and to cordially join the medical staff in the proposed anniversary dinner.

DR. D. C. MORGAN, of Bairnsdale, was sued in the local County Court, on October 6, by Mrs. Gray, a widow, for damages for breach of promise of marriage. The lady recovered a verdict for £1000 against Dr. Morgan.

THE trial of Mrs. Elizabeth Taylor for the murder of the girl Georgina Warburton, through causing her death by the performance of an illegal operation for abortion, was concluded on September 28. The jury returned a verdict of manslaughter with a strong re-

commendation to mercy. Prisoner was allowed out on bail, pending the decision on a law point reserved in her favor.

MR. ROBERT COLQUHOUN, L.R.C.P. Edin., L.F.P.S. Glas., 1867, who for the past nine years has occupied the position of resident surgeon at the Clunes District Hospital, died at Sandhurst, on September 11. The deceased gentleman had been in failing health for many years, and recently arranged for leave of absence for three months to recruit. He left for Sandhurst on September 10, on a visit to his cousin, Dr. Colquhoun, of the Bendigo hospital, but the journey proved too much for his strength, and its effects were fatal to him. His death is greatly regretted in Clunes and the surrounding district.

DR. H. W. BRYANT has commenced practice at Williamstown.

DR. A. F. DAVENPORT, late of South Melbourne, has commenced practice in conjunction with Dr. Rankin, St. Kilda, a fashionable suburb of Melbourne.

DR. CHRISTOPHER A. GRIFFITH, recently arrived from London, has commenced practice at Carlton (Melbourne), in conjunction with his brother, Dr. James De B. Griffith.

DR. R. P. RANKIN, of St. Kilda, Melbourne, has been appointed medical Officer of the Walgett hospital.

DR. JAS. SMEAL, of Seymour, has removed to Charlton, on the Avoca river, 173 miles N.W. of Melbourne.

DR. R. A. STIRLING has returned from his trip to Europe, and resumed practice at his former residence, 78 Lonsdale-street East, Melbourne.

DR. D. W. B. WILKIE, late of Junee Junction (N.S.W.), has settled at Winchelsea, on the Barwon river, 71 miles S.W. of Melbourne.

WESTERN AUSTRALIA.

DR. N. W. HOLMES of Guildford, has resigned his appointment as District Medical Officer and Vaccinator for the Swan district. Dr. F. Tratman, of Gascoyne, has been appointed to act temporarily in his place.

DR. T. FRIZELL, a new arrival, has settled at Roebourne, the centre of the famous pearl-fisheries on the N.W. coast, 950 miles N. of Perth.

BIRTH.

HACON.—On August 4, the wife of W. E. Hacon, L.R.C.P. Lond., Medical Superintendent of the Hospital for the Insane, Christchurch, N.Z., of a son.

MEDICAL APPOINTMENTS.

Allen, William Robert, L.R.C.P. & R.C.S. Ed., to be Public Vaccinator at Kingston, Vic.

Cottew, Arthur Atwool, L.R.C.S. Irel., L.R.C.P. Edin., to be Public Vaccinator for the District of Gore, N.Z.

Frizell, Thomas, M.D., to be District Medical Officer and Public Vaccinator for the North District, W.A.

Griffiths, William, L.S.A. Lond., to be Govt. Medical Officer and Vaccinator for the District of Broken Hill, N.S.W.

Moloy, Charles Henry, M.B. & Ch.B. Melb., appointed Resident Medical Officer at the Melbourne Hospital, Vic.

Smeal, James, L.F.P.S. Glas., to be Public Vaccinator at Charlton, Vic., vice Dr. H. C. Gee, resigned.

Symes, Richard Henry, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Surgeon in the Queensland Defence Force.

Tratman, Frank, M.B., to be District Medical Officer and Public Vaccinator for the Gascoyne District, W.A.

Withers, Thomas John, M.D. & Ch.M. Qu. Univ. Irel., to be an additional Public Vaccinator for the Ellesmere District, N.Z.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards : —

NEW SOUTH WALES.

Edmunds, Daniel Taylor, L.R.C.P. Edin., 1883; M.R.C.S. Eng., 1883.

Cotterell, William, L.R.C.P. Edin., 1871; L.S.A. Lond., 1870; M.R.C.P. Edin., 1882.

Bennett, Frank Albert, M.R.C.S. Eng.; L.R.C.P. Lond.; L.S.A. Lond.

McGuire, William Walter, M.B. & Ch.B. Melb., 1881.

NEW ZEALAND.

Pairman, Thomas Wyld, L.R.C.P. & R.C.S. Edin., 1883.

TASMANIA.

Gutteridge, Matthew Wilkins, M.B. & Ch.M. Edin., 1883; M.R.C.S. Eng., 1883.

VICTORIA.

Griffith, Christopher Arthur, M.R.C.S. Eng., 1884.

Bryant, Henry William, L. & L. Mid. R.C.P. Edin., 1885; L.R.C.S. Eng., 1886; L.F.P.S. Glas., 1885.

Stevenson, Bernard, L. & L. Mid. R.C.P. Edin., 1884; L.R.C.S. Eng., 1884.

Macmillan, Alexander Ronald, M.B., Ch.M. & L. Mid. Edin., 1885.

Additional qualification registered:

Lane, Charles Timon, Ch.B. Melb., 1886.

WESTERN AUSTRALIA.

Frizzell, Thomas, M.D.

Tratman, Frank, M.B.

PUBLICATIONS RECEIVED.

The Principles of the Treatment of Fractures and Dislocations. By Hugh Owen Thomas. London: H. K. Lewis, 1886.

The Diseases of the Prostrate: Their Pathology and Treatment. By Sir Henry Thompson. Sixth Edition. London: J. & A. Churchill, 1886.

Inflammations of the Liver, and their Sequela: Atrophy, Cirrhosis, Ascites, Hemorrhages, Apoplexy, and Hepatic Abscesses. By Dr. Geo. Harley, F.R.S. London: J. & A. Churchill, 1886.

Bright's Disease and Allied Affections of the Kidneys. By Charles W. Purdy, M.D., Professor of Genito-Urinary and Renal Diseases in the Chicago Polyclinic. London: H. K. Lewis, 1886.

The Peroneal Type of Progressive Muscular Atrophy. By Howard H. Tooth, M.A., M.D., M.R.C.P., of St. John's College. London: H. K. Lewis, 1886.

The Liverpool Medico-Chirurgical Journal, including the Proceedings of the Liverpool Medical Institution, for the half-year ending June, 1886. London: H. K. Lewis.

Synopsis of Therapeutics, with Posological Tables and an arrangement of the Poisons. By R. S. Aitchison, M.B. Edinburgh: Young J. Pentland, 1886.

Paralysis: Cerebral, Bulbar, and Spinal. A Manual of Diagnosis for Students and Practitioners. By H. Charlton Bastian, M.A., M.D., F.R.S., Professor of Clinical Medicine and of Pathological Anatomy in University College, London. Illustrated. London: H. K. Lewis, 1886.

Massage as a Mode of Treatment. By William Murrell, M.D., F.R.C.P., Lecturer on Pharmacology and Therapeutics at the Westminster Hospital. London: H. K. Lewis, 1886.

Handbook of Diseases of the Ear, for the use of Students and Practitioners. By Urban Pritchard, M.D., F.R.C.S., Professor of Aural Surgery at King's College. London: H. K. Lewis, 1886.

REPORTED MORTALITY FOR THE MONTH OF AUGUST, 1886.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Measles.	Number of Deaths from									
						Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.	
N. S. WALES.															
Sydney	125,000	345	209	67	...	5	3	...	2	1	23	22	12	14	
Suburbs	175,000	888	262	115	...	4	1	8	6	9	17	19	19	16	
NEW ZEALAND.															
Auckland	33,161	96	38	8	...	...	...	...	...	...	8	1	4	8
Christchurch ..	15,265	23	25	14	4	...	1	...	...	...	1	1	4	...
Dunedin	23,243	67	37	16	...	...	...	8	...	1	5	8	6	5
Wellington	25,945	92	33	12	2	...	...	...	...	3	4	5	5	5
QUEENSLAND.															
Brisbane	32,571	116	32	16	...	6	1	2	...	12	...	4	..	..
Suburbs	19,112	77	35	10	...	...	...	...	...	...	13	3	1	1
SOUTH AUSTRALIA.	316,249	943	245	87	...	1	10	1	3	2	27	17	9	13	
Adelaide	58,000	87	58	14	...	...	...	...	1	1	13	3	1	1
TASMANIA.															
Hobart	29,464	91	34	14	...	1	2	1	...	...	4	9	2	6
Launceston	18,576	54	27	11	...	1	2	...	...	5	5	3	3	1
Hospitals, Asylums, Gaols, &c. .	1,271	...	40	...	...	...	...	...	...	...	...	...	...	...
Country Districts.	85,576	244	76	...	...	1	...	...	...	1	...	...	...	...
VICTORIA.															
Melbourne	69,774	150	78	24	1	15	6	12	6	79	34	31	75	..	
Suburbs	275,606	1,022	486	170	2	...	...	...	...	...	...	...	...	...

METEOROLOGICAL OBSERVATIONS FOR AUGUST, 1886.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Mean Shade.		Depth.	Days.	
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	73·1	54·4	38·6	29·733	...	Inches	...	..
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	125	62·	52·	36·0	...	5·680	29	74	..
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	145	80·	64·6	42·5	30·040	3·83	9	74	W.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	118	55·2	40·5	31·	...	8·429	25	84	..
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	115	53·	42·2	31·	...	19·552	27	85	..
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	61·3	48·1	33·	29·772	2·53	20	85	..
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	60·	47·2	28·2	29·822	4·77	18	78	..
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	68·1	49·8	32·9	29·783	2·45	15	..	..
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	69·3	55·9	43·8	29·937	2·17	14	74	W.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	115	57·	46·5	32·	...	6·340	27	86	..

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

A CASE OF CÆSAREAN SECTION— PLUS OÖPHORECTOMY—DEATH IN 32 HOURS.

BY THOMAS CHAMBERS, GYNÉCOLOGIST TO THE
SYDNEY HOSPITAL, AND LECTURER ON MID-
WIFERY AND DISEASES OF WOMEN AT THE
SYDNEY UNIVERSITY; LATE SENIOR PHYSI-
CIAN TO THE CHELSEA HOSPITAL FOR
WOMEN, LONDON, AND TO THE PRINCE
ALFRED HOSPITAL, SYDNEY.

OUR vanity is always humiliated by defeat; nevertheless, if the contest has been honest and well sustained by every means at our command, even defeat is robbed of much of its bitterness.

The Cæsarean Section is an operation of great antiquity, and has excited more discussion in the obstetric world than almost any other operation connected with midwifery. Even now opinions greatly differ as to its merits and demerits. That the operation has attained a patriarchal age is attested by Shakespeare, who tells us that "Macduff was from his mother's womb untimely ripped," to say nothing of Julius Cæsar, Æsculapius, and a host of other notables of primeval days.

Mrs. H., æt. 29, a woman of stunted growth and old-looking, was delivered of her first child by Dr. C. R. Watson about 3 years ago. The labor was protracted, and she was ultimately delivered of a dead child by instrumental aid after great difficulty, from the effects of which she appeared to recover fairly well. In the last week in August of this year the husband called on Dr. Watson—who had not seen the wife since her last confinement—and told him that his wife was again

expecting, that she was very unwell and wished to see him, although she did not think herself advanced beyond the eighth month, but about this she could not be sure. The doctor called, and on making an examination, he found the vaginal arch drawn up into a cone. At the top was a small granular fossa in the centre of which was a small opening just large enough to admit a sound, but no uterine cervix or os could be made out. He could distinctly outline the child through the thin attenuated abdominal walls, and by auscultation could hear the foetal heart sounds. On passing a speculum he could see the small opening in the vaginal arch, through which was percolating a purulent-looking fluid in considerable quantity. As he was somewhat perplexed as to the exact nature of the case, he asked me to see the patient with him on the afternoon of August 25. After a careful examination I came to the conclusion that the soft parts had been injured during her previous confinement, and that adhesive inflammation had supervened, resulting in complete closure of the vagina at its upper third, with the exception of the small granular opening permitting egression of menstrual and ingressions of seminal fluids. The sound passed through the opening about an inch and a-half into a *cul-de-sac*. With the left index finger in the rectum this *cul-de-sac* could be clearly made out to be a part of the vagina, and the rectovaginal wall at this part was remarkably thin, through which the lower zone of the uterus could be easily outlined as well as sundry cicatrical bands. The antero-posterior diameter of the pelvis was observed to be diminished, partly through flattening of the pubic arch, and partly through undue projection of the sacral promontory.

The diminished capacity of the pelvis and the extreme improbability of being able to dilate the vagina sufficiently to admit of the safe extraction, even of a mutilated child, through the natural passages, pointed to the Cæsarean Section or one of its modifications as the only alternative. In this opinion Dr. Watson cordially acquiesced.

When we made the friends acquainted with our views they were a little surprised at the serious nature of the case, but we urged upon them the importance of immediate action in the interest both of mother and child. The child's heart sounds were distinctly clear but somewhat slower than normal, while the mother's temperature and pulse were both abnormally high, 101.5 and 136 respectively—important indications of the necessity of active measures. Another consultation

was suggested, in which my friend, Dr. Knaggs, took part. By this time the foetal heart sounds had so much diminished both in force and frequency, that its safety appeared to be almost out of the question. Dr. Knaggs was also of opinion that the only chance for the mother was in immediate operation. But there were two objections to this course, viz., the necessity for consulting friends, and the unsavoury surroundings of the patient. In order to give her the best chance for her life I offered to take her into my private hospital—the accommodation in my department at the Sydney Hospital being then incomplete. She was admitted late in the afternoon of Friday, Aug. 27, and was a good deal fatigued by the journey. I ordered her a sedative to give her a little rest and such nourishment as she could take, and with a view to secure a free escape for the lochial discharges I passed a tent into the opening in the vaginal roof.

28th, 9 a.m.—She has passed a quiet night, and has slept fairly well; she was cheerful and hopeful for the future. The vaginal discharge was very offensive; the tent was removed and the passage freely irrigated with warm carbolized water. The finger could now be passed through the opening into the *cul-de-sac*, which was found to be extensively ribbed with numerous cicatrical bands of considerable density. The cervix was well dilated by the child's head, presenting in the first position; the membranes being ruptured. On passing the left index finger into the rectum, the recto-vaginal septum in the upper vaginal segment was found to be exceedingly thin. A sponge tent, as large as the opening would conveniently admit, was introduced, and directions given to have the bowel well cleared by a turpentine enema, to be repeated until it was well cleared out.

Soon after 2 o'clock Dr. Knaggs aetherised the patient, Drs. Goode, Pickburn, C. R. Watson, R. T. Jones, Grigson, Worrall, and Mr. Rutledge being present. The sponge tent was removed and the vagina well irrigated with carbolized warm water. A careful examination was again made, and a general consultation was held as to the propriety of attempting to deliver by the natural passages. The united opinion was unfavourable to this course and in favour of abdominal section as the only course likely to offer the patient a chance of life.

The bladder having been emptied, Dr. Goode took his place on the left of the patient and steadily pressed the uterus forwards towards the median line. The incision was carried from the umbilicus to within an inch and a-half of the pubic margin. Having secured the bleeding points, which were very few, the peritoneum was opened. A soft cloth rung out of hot carbolized water was now carefully packed between the

incised wound and the uterus with the double object of keeping in the intestines and keeping out of the abdominal cavity anything escaping from the uterine wound. Auscultation was now practised, but no placental souffle could be made out. This may be easily accounted for by the death of the foetus. The uterus, which was much distended and uniformly tympanitic, was now pressed well into the abdominal wound by Dr. Goode. Two strokes of the knife reached the uterine cavity, which event was signalized by the sudden and noisy escape of a large quantity of very foetid gas. The placenta was found immediately under the incision. The right hand was quickly slipped between the placenta and uterus, the child seized and extracted by the breech, the left hand bringing up the occiput. The uterus quickly contracted and expelled the placenta immediately after the head, so that the child and placenta were handed together to the nurse. As there was very little bleeding the uterus was now enveloped in a soft cloth squeezed out of hot carbolized water, and supported by the two hands with the twofold object of allowing the patient a little rest and time for the uterus to contract. In a few minutes the cloth was removed, and Dr. Goode inserted his index fingers, one into each angle of the uterine incision, and drew it forwards well into the abdominal wound, while I removed the coagula from its cavity and washed it well out with hot carbolized water (110° F.), until it escaped through the vagina free from any blood stain: on the posterior wall near the fundus was seen a circular patch of a dark grey colour like gangrene. In the meantime the uterus had so closely contracted that sutures appeared almost unnecessary. The peritoneum did not contract with the same facility as the muscular tissue, and was corrugated into folds so as completely to obliterate the uterine incision. A drainage tube was passed through the vaginal opening into the uterus, and five interrupted silk sutures closed the uterine wound, and its peritoneal margins were easily and accurately adjusted. When the cloth which had been first placed between the uterus and the abdominal incision was removed, it was found that nothing had escaped into the peritoneal cavity. The uterine appendages were easily removed and the abdominal wound closed and dressed as in ovariotomy, and the patient removed to her warm bed. Reaction was both rapid and complete. Two hours after the operation the patient had perfectly recovered from the effects of the anaesthetic. She had neither sickness nor pain, and expressed herself as feeling quite well, and asked if she might have a chop. Every 15 or 20 minutes she had a contracting pain in the abdomen like after pains, but they soon passed off and gave her but little discomfort. With the

exception of an abnormally high pulse (146), her prospects appeared very promising ; temperature, 102·5. When the operation commenced, her temperature was 102·8 ; pulse, 140 ; and respiration, 28 to 30. No sedative was necessary ; diet, iced milk and thin peptonised food at short intervals, which she could take exceedingly well, with peptonized food and brandy enemata every 6 hours, at which times the catheter was used. When these two little offices are performed simultaneously they save the patient from unnecessary disturbance.

11 p.m.—Feels comfortable and very grateful for the great relief she has experienced ; has slept a little. The uterine contractions still continue at regular intervals. To continue nourishment ; no medicine necessary. The temperature has fallen to 101·, but the pulse was small, quick, and thready. As eight hours had now passed since the operation, and the pulse showed no signs of falling, while the temperature was doing so somewhat rapidly, I regarded this as a very unfavourable omen. Experience has taught me to look upon such symptoms as almost uniformly fatal. This great divergence of temperature and pulse has always been a bad omen in my experience, especially if the pulse keeps abnormally high. I have much better expectations if the pulse falls and the temperature keeps up. This divergence usually adjusts itself in a few days ; while in the former case the patient's life is usually limited to hours. In the course of years I have tried many forms of medicine in such cases, but with little, if any, success. Nevertheless, I thought it only right to try that kind of combination which has appeared to me to be of most value, viz., carbonate of ammonia with cinchona, digitalis, and opium in chloroform water, but, as usual, with little or no result. The lochial discharge appeared healthy and in fair quantity. I washed out the uterus with a double catheter, the fluid returning through the drainage tube quite clear and free from smell.

29th, 2 a.m.—Has slept comfortably since my last visit, and is in all respects much the same, save in the temperature which has fallen to 100, while there is no fall in the pulse ; on the contrary, its tendency is to quicken. The lochial discharge continues satisfactory. To have a little brandy added to the food, in other respects to continue as before.

9 a.m.—Has on the whole passed a quiet, restful night. She looks cheerful, and was hopeful as to the result. The uterine pains still continue, but at greater intervals and are less powerful. The lochial discharge appears healthy and in normal quantity. The drainage tube was withdrawn, and the uterus well irrigated with warm carbolized water ; no offensive smell ; tongue

clean and moist ; temperature, 99°, with a slight disposition to loss of surface heat ; pulse, 150, very small and jerking ; no nausea or sickness, neither was there any tympanitic distention ; to have as much stimulant as she can take.

2 p.m.—In most respects much the same, the temperature and pulse excepted. The former is falling while the latter is increasing in frequency and indistinctness. With this gradual divergence of temperature and pulse the prognosis assumes the gravest aspect. The respirations have increased to 38 or 40, and are shallow with frequent sighing ; no tympanitic distention, sickness, or abdominal tenderness.

From this time she gradually became weaker, and quietly died at half-past one on the morning of the 30th, about 82 hours after the operation, the mental faculties remaining clear to the last.

An after-death examination was not obtainable, but the abdominal wound appeared to be completely united, and the uterus was well contracted.

It may very naturally be asked, what was the cause of death ? It is manifest, I think, from the history of the case, that haemorrhage, peritonitis, and metritis, as factors, must be eliminated. But there are three other important factors which do not admit of elimination, viz., nervous shock, exhaustion from over long delay in operating, and pæparturient septicæmia. That each of these performed its part in the fatal programme I cannot doubt, the nervous shock being a primary cause.

The Cæsarean Section has not been attended with any great amount of success. This, however, has been due, in the main, to the fact that the operation has usually been, from various causes, deferred until success was almost hopeless. But Harris and others have shown that the operation is a very hopeful one if undertaken while the patient is comparatively fresh and unexhausted.

Inasmuch as the operation is always, and of necessity, associated with great danger, it is only justifiable when delivery by the natural passages involves still greater peril. Under whatever circumstances, therefore, the patient is found, our duty is clear enough, viz., to do the best we can for her and her offspring if it is still living.

In considering the case before she came in for operation, the question naturally suggested itself—Could the woman, if she survived the present difficulty, be saved from a similar ordeal ? If so, how ? By Porro's operation, or by the Cæsarean Section plus oophorectomy ? It has always appeared to me that the simple Cæsarean Section is an incomplete procedure, inasmuch as it only deals with effects, leaving causes undisturbed : hence the operation has had to be repeated again

and again on the same woman. Porro's operation has only been moderately successful; it gives rise to an excess of nervous shock, while it is not by any means free from septic complications.

I was induced to elect the Cæsarean Section plus oophorectomy, (1) because it would be attended with less shock than Porro's operation; (2) because the removal of the uterine appendages would as completely secure the woman against a future pregnancy as Porro's operation, while the uterus would be left; and (3) because oophorectomy is comparatively a simple operation, and is attended with less risk to life than any other operation, involving the peritoneum under ordinary circumstances, and when associated with the Cæsarean Section its influence for evil must be reduced to a minimum. In the case under consideration its influence on the result must have been nil. In 21 cases of oophorectomy by the abdominal section only one died, and that could not justly be chargeable to the operation. My temperature charts show a wonderful uniformity in the course of these operations. There is no rise in temperature until the third day, when it rises to 100 on the average. At this time a form of uterine epistaxis appears, and as this comes on the temperature falls to 99 or lower, and never rises again more than a point or two, if at all. In 20 of my 21 cases this has been the usual course. I therefore infer that the addition of oophorectomy to the Cæsarean Section in the case under consideration had nothing whatever to do with the result.

The objection, in some minds, to Porro's operation (the same objection would apply to this) is that it unsexes the woman. I fully admit that such a woman will be incapacitated for child-bearing; but is this an evil? I frankly confess that I regard it as an unmixed good. If a woman is, from any cause, so much diseased or deformed as to demand such a mode of delivery surely she should be regarded as unfit for the important functions which pertain to child-bearing.

As to what is meant by unsexing, beyond the incapacity for child-bearing—a condition often enough met with in women perfectly well formed—is a question more easily asked than answered. It is quite certain that such a woman is not incapacitated for sexual life of a satisfactory kind.

A careful review of this case will, I think, justify us in concluding that the operative procedure adopted was justifiable, and that the addition of oophorectomy had no influence on the result, the only cause for regret being the unavoidable delay. There is the best reason for believing that if the operation could have been done 48 hours sooner both mother and child might have been

saved—at least the mother. Although this is the first case of Cæsarean Section plus oophorectomy—as far as I know—I am very much inclined to the opinion that it will not be the last, notwithstanding its failure. I have long thought that the Cæsarean Section has been placed under greater disadvantages than any other abdominal operation in consequence of being almost uniformly deferred until the patient's vital powers have been so depressed by delay, exhausting and useless attempts to deliver, that all prospects of success were gone.

But Harris has shown that if the operation is deliberately undertaken before any attempt at delivery has been made and while the patient is fresh and in a fair condition for sustaining such a formidable operation, it has been attended with wonderful good results. I see no reason why (if the proper moment can be selected) this operation should not be a good alternative to craniotomy, and attended with as much success at least as characterised ovariotomy twenty years ago, or attends extirpation of the uterus at the present day. If this alternative were adopted, under favourable conditions, its advantages would be—(1) The child would not be exposed to greater peril than attends an ordinary delivery, while in craniotomy it must of necessity perish. (2) The mother would not be exposed to greater danger than when craniotomy is performed: when all other means of delivery have been tried and failed—perhaps the risks would not be nearly so great in the majority of cases; and (3) the mother would be secured against the possibility of a future impregnation and its consequences, while she would still retain her uterus. These are advantages which I venture to submit for your consideration and criticism.

With regard to the use of sutures to the uterine wound, I would just say a word or two. While I think sutures essential, I do not think they need be so formidable as at present recommended in most text books. Those writers who give particulars say the needle should be inserted half an inch from the wound margin, and directed in a slanting direction until its point appears at the junction of muscular and mucus tissues of the organ. If these directions were modified one-half, every object for which the sutures are used would be obtained, while they would cause much less irritation. A continuous suture, such as I have successfully used in rupture of the bowel, would answer every purpose.

I may remark that the galvanic current was used both before and after the introduction of the sutures, with but little, if any, apparent result.

A VISIT TO M. PASTEUR.

By W. W. McCOWIRE.

Now that the attention of scientific circles in almost every country is, and has been for some little time, directed to the recent discoveries made in France towards the preventive treatment of hydrophobia, perhaps it may interest your readers to learn some account of a visit paid by me not so long ago to the laboratory of its illustrious exponent in Paris. On the 5th November last I called upon M. Pasteur at 45 Rue d'Ulm, Quartier Latin, near the Pantheon, introduced myself as an Australian practitioner, and was most kindly received. This was about the time when preventive inoculation was just commencing to become general. On my arrival there were fully a dozen people awaiting treatment, among them four sisters who had been recently bitten by a pet dog. M. Pasteur first showed me over his establishment in which were at least 150 animals of different kinds, kept for experimental purposes, such as dogs, monkeys, a number of rabbits, guinea pigs, mice, pigs, fowls and pigeons, none of which ever leave the place alive, as those not susceptible to inoculation are destroyed for safety's sake by strychnine. But before entering into an explanation of his researches in the direction of rabies, M. Pasteur, to facilitate my better understanding of his most recent studies, detailed to me the history of his experiments for the prevention of Charbon or carbuncular disease in the lower animals, it having been through deductions arrived at in the study of this latter that he was first led to investigate the true nature of hydrophobia. It appears certain that the poison of anthrax resides primarily in the bacteria of affected fluids, and secondly in the spores or bodies developed from them under ordinary circumstances. It is further known that the bacteria will not live at a temperature of over 50° C., whereas to destroy the spores one of 100° C. is required. Now, if a perfectly pure sample of veal or chicken broth be taken, that is to say one in which all possibility of the pre-existence of animal life has been carefully excluded according to Professor Tyndall's method, and a drop or two of carbuncular blood be added to it, it is found that by keeping such a fluid simmering for several days at a temperature of from 40° C. to 43° C., two results follow: one, that the bodies of the bacteria become thinner and more elongated, varying according to the time this heat is kept up; the other that the spores are never under such conditions developed. If then a very weak solution be taken, that is one

in which such a heat has been maintained for a considerable time, a domestic animal may be safely inoculated with it (say No. 1) preparatory to his being subjected to a second injection from a stronger solution (No. 2), which fortifies him against one to which heat has been applied for a still shorter time (No. 3). But in practice it has been found that one inoculation affords ample protection, and that the strength of such a liquid is sufficient only to kill a mouse. In this manner M. Pasteur, as principal of an ordinary trading company, prepares a very large number of sealed tubes containing this liquid which he sends all over France and other parts of Europe besides, either to veterinary surgeons or the owners of stock direct. The cost of inoculation is only a penny per head, and the practice, which has now become pretty general, is invariably attended with the best results. Indeed I have heard it said that in this and other ways M. Pasteur has actually saved France in cash more than the two hundred millions sterling paid over to Germany in 1871. I was then brought over to see the hydrophobia section, in which were several animals dead or dying from rabies—dogs either frothing at the mouth or suffering from the dumb form of the disease, but the rabbits and guinea pigs perfectly paralysed. If cultivations be required, a little fresh saliva from the dog is taken, and a rabbit spread-eagled on a piece of board by means of string attached to his four legs; he is then chloro-formed, the skin over the cranium divided and the bone trepanned with a very fine instrument which removes a piece about the size of a split pea. Hydrophobia being essentially a nerve poison, a delicate needle is then slipped through the dura mater, making but the smallest wound, and through it a drop or two of a strong preparation of saliva direct from the dog is injected right on to the surface of the cerebral hemispheres; the skin is next stitched up and the animal allowed to awake, which he usually does in a very few minutes, apparently none the worse. One of two things then happen: either that the rabbit, being idiosyncratically proof against the virus of rabies, takes no harm, just in the same way that some among ourselves are proof against the poison of small-pox; or else, what far more commonly occurs, he develops symptoms of rabies in from six to eight days. And here commences that part of the study which is of most practical interest to man, though fortunately for us in this country, of much less than to people residing in the old world or America. The poison of rabies, unlike that of small pox and most other animal poisons, vanishes within 24 hours of death, so, shortly after

this has occurred, the operator, taking the greatest care not to get inoculated himself, extracts about two inches of this rabbit's spinal marrow, and places it in a perfectly air-tight jar having at the bottom some pieces of caustic potash in order to remove all moisture, and so preserve the specimen a little longer than otherwise it would keep. During this time, if required for use, it is cut up, immersed in a vessel containing a perfectly pure veal or chicken broth, which is then hermetically sealed and subjected to the vapour bath at from 40° C. to 43° C. for a comparatively short time in order to obtain a very strong cultivation. From a little of this solution a second rabbit is injected, his spinal marrow treated in precisely the same way, but subjected to the vapour bath for a longer period in order to produce a weaker fluid for injection. A third rabbit is then inoculated from this latter, and so on, till at length as many as perhaps twenty have been so destroyed, those cultivations used for the latter inoculations being so mitigated by long exposure to heat as only just sufficiently strong to kill. A portion of the liquid employed for each injection has meanwhile been hermetically sealed, carefully labelled and set aside, so that here are a number of cultivations each of a known graduated strength capable of producing certain definite effects. I do not profess to be able to say how long each solution is kept simmering in the vapour bath, nor whether the rabbits treated by the weaker cultivations all die within six or eight days; probably not. What is here desired to be conveyed is that the longer heat is applied to any given solution, the weaker is the resulting cultivation, and *vice versa*. Again, one might think that if the spinal marrow of the first rabbit were cut up into twenty different pieces, immersed in separate vessels each containing a pure broth, and subjected to the vapour bath for varying periods, the result would be twenty solutions of a graduated strength quite as useful as those obtained from the marrow of a number of different rabbits: but this is not so. To render the inoculatory fluids perfectly safe as well as certain for human use, M. Pasteur makes a point of passing the hydrophobia virus through the bodies of several rabbits, and so far as I am aware up to the present time, the spinal marrow of this animal has been the sole medium of preventive inoculation between the rabid dog and man. He informed me that there was no necessity for injections if the bitten part of either man or animal be at once cauterised, and that further inoculations to be effective must commence to be practised within a few hours, at most some 48 or so. Should the patient defer treatment till active symptoms of hydrophobia set in, then injections are too late and altogether useless. Sup-

pose, however, a patient be brought to him within a limited time, then, without regard being paid to the local injury, inoculation is at once practised over the region of the heart, commencing at the weakest cultivation (say No. 20), which is followed up next day by a similar use of No. 19, on the day following No. 18, and so on till No. 1 solution is reached, by which time the system has become so thoroughly inured to the circulation of a mitigated virus that whether the person subjected to this treatment have been previously bitten or not, it is perfectly safe to inject him with saliva direct from the living dog. He has become, in short, hydrophobia-proof, just as a person who has been successfully vaccinated becomes variola-proof; but as the discovery is only of very recent date, it is impossible for anyone yet to say for what length of time immunity is thereby conferred. M. Pasteur had not, at the period of my visit, obtained any one single solution which he could guarantee as of itself a specific against hydrophobia, such as he has discovered in the case of Charbon; but he regards that merely a question of time. Neither has he yet been enabled to isolate microscopically the active bioplasm of hydrophobia. But it is quite certain such a thing exists, probably much resembling in physical appearance the bacilli of Charbon, jointed rod-like bodies, which I saw most distinctly at 800 diameters lying among a heap of broken colourless corpuscles tinted blue by litmus. A curious fact in connection with these living poisons pointed out to me is that, under ordinary circumstances, a virus which multiplies itself within the bodies of animals, mostly large, and having a comparatively low temperature, is perfectly harmless to other, mostly smaller, creatures whose normal condition registers a higher. For example, the temperature of the domestic fowl is about 45° C., and that at which the virus of Charbon must be kept in order to render it inert is from 40° C. to 42° C., so that carbonaceous virus injected into blood at such a temperature is quickly neutralised and overcome. If, however, the temperature of that fowl be artificially reduced by keeping its feet in iced water for some little time previously, then it will at once receive the virus and die of acute blood-poisoning within 24 hours. I was also shown some of the celebrated Koch's original cultivations preserved in absolutely pure gelatine. It was very curious to see how the germs of fowl cholera had spread like a plant by propagation through the mass which had subsequently become solidified around them. The above notes are transcribed from jottings made by me immediately on my return to my hotel, and most of the various steps which I have endeavoured to describe were carried out in my presence, and I believe, repeated daily. The preventive treatment

of hydrophobia is now reduced almost within exact lines, and by this time hundreds have availed themselves of the discovery, patients finding their way to M. Pasteur from nearly every corner of Europe, with the best results whenever there has been anything like a fair chance given. What interested me most after these wonderful discoveries themselves, was the man who had made them, the hard practical way he has of regarding facts, the great care he takes to consider any given subject from every conceivable point of view before expressing an opinion, and then the absolute certainty with which he gives it.

RECOLLECTIONS OF A COUNTRY PHYSICIAN.

BEING THE TRIALS, TRIUMPHS, AND DISAPPOINTMENTS OF PROFESSIONAL LIFE.

COPIED FROM HIS FATHER'S NOTES, BY WALTER DUNN, B.A., CANT.; M.R.C.S.E.; OF ROXBURGH, OTAGO, NEW ZEALAND.

II.

SOON after the striking cure which was published in the August number of the *A.M.G.*, a hard-working, sincere, and zealous clergyman from the north, ministering to a large and poor parish, being blessed like Mr. Quiverfull, and his purse very scantily furnished, came 100 miles to consult me. He had been under treatment some months, and, as he thought himself in a dying state, some kind soul recommended him to obtain leave of absence from the Bishop of Durham, and go to Yorkshire and put himself under my care. He presented himself one forenoon, and as he came from such a distance, I was put on my mettle, and examined him thoroughly, to find what? There was nothing at all the matter with him! In great anxiety he asked me if I thought there was any chance for him, adding, at the same time, that I need not fear to tell him the truth, as he had given up all hopes of recovery. I put on a very grave face, and said if he would obey my instructions to the letter, I could give him the assurance of a perfect cure. As I was an apothecary, as well as M.D., and dispensed my own medicines, he asked me if he should wait for the medicine, and, to his great surprise and pain, I replied that I could not make his medicine that day, but if he would call at the same hour on the morrow I would have the medicine prepared. He then asked if I was sure he would live till next morning. I assured him of that, but he begged hard to have his medicine that day, which was impossible, seeing I had not got it. He reluctantly

left, saying that he would call next day. When I had finished my work, I went to a toy shop and bought two battledores and some shuttlecocks, and on his presenting himself on the following morning, I begged him not to let the shuttlecock fall, but to send it back several times. He put his hand to his chest, and said what he felt, but I kept at the game for an hour, and then, bidding him good morning, I hurried off to my work, leaving him very much better, and very much astonished at my strange behaviour.

I made him promise to return every morning, which he did for a parson's fortnight, when I dismissed him cured. On my patient's return to his parish, so enamoured was he with the game, that he would have all his friends play with him. This worthy gentleman is now the esteemed rector of Boldon, is 82 years of age, and in good health.

This case shews the necessity of accurate diagnosis.

I have said that from the kindness of a medical friend I was introduced to my first aristocratic patient, who had also an estate in Wales. I received a letter one morning, stating that the family was returning home, and that Mr. P. D. C. would be glad if I would meet them on their arrival which of course I did. All the family, with their servants, arrived at 8 p.m. After the first warm greeting, my patient, the kindest and most liberal of men, visited all the servants, and on going to the stables, inquired for a boy named Levick. The groom said he was in bed ill, on which Mr. C. ran up and found the boy delirious. Mr. C. came to me in great distress to tell me that Levick was very ill, and that the doctor he had applied to had not seen him for three days, and he begged me to go and see the case. I asked him to send for the doctor, that we might see him together. This he declined to do, and put the youth under my care. I then saw the boy, who was suffering from typhoid fever. I immediately ran to Mr. C., and intreated him not to unpack the carriages, as I feared it would not be an isolated case. Both he and his lady scouted the idea, and told me they were determined to remain. I then asked to be exonerated from blame should the fever attack any of the family. I was thanked for my disinterestedness, and I attended the boy, who recovered. One of the sons, Willie, then James, and, lastly, Mr. C. took the fever; all, however, happily recovered. This is not at all singular; but what is singular, the gamekeeper and several who took the disease, and were attended by others, died; this was owing at the time to the small amount of the knowledge then known of the treatment of this dangerous fever.

ON TUBERCLE, CONTAGION AND HEREDITY.

BY F. W. ELSNER, F.R.C.S.I., MELBOURNE.

(Continued from page 15.)

THE *Berliner Klinische Wochenschrift* of Aug. 30, 1886, has just come to hand, and contains a graphic account by Dr. Elsenberg of a case of tuberculosis induced by a phthisical man performing circumcision on a child which became infected, bacilli being found in the sputum of the man and in the inguinal glands of the child, which broke down and ulcerated. The operator, as is well-known, when performing circumcision, removes the foreskin with a sharp stone and then sucks the prepuce to stop bleeding, etc., a vile habit which has caused the infection of numerous children no doubt—and 10 cases have been reported by Lehmann, and two by Lindemann, where, however, the bacillus was not sought after, and the diagnosis therefore was arrived at empirically.

Tscherning reported one case of inoculation last year in which a girl wounded herself with a piece of glass from a vessel used by a phthisical patient as a spittoon. Her finger was removed, as were also the cubital and axillary glands which had become infected, and bacilli were found in all these situations. It is by means of thorough investigations such as these that the truth of this matter will only be arrived at.

I may be pardoned for describing a few cases which I have met with in practice to illustrate what I mean.

Mrs. S. N., set. 35, delicate, fragile, with two children alive, no family history, but history of twelve years cough and expectoration, &c.; physical examination showed the whole of the left upper lobe gone, a large cavity with metallic tinkling and amphoric breathing and cracked pot sound. *No bacilli in sputum.* Coghill's respirator and carbolic acid in Spts. chloroformi for inhalation ordered, also malt extract, cough mixture and tonics, together with change of air and plenty of exercise, which, however, was very moderate owing to the weak condition of the patient; a fairly favourable prognosis was given, and six months later the left side of the chest showed contraction, cough and expectoration vanished, and patient put on flesh. Last month I was called out one evening to see my old patient who had, for the first time for five or six months, had a fit of coughing, during which blood welled into her mouth, but when I arrived she was dead; the contracted, cicatrised lung had been rent by the coughing, and pulmonary apoplexy had

emptied all her vessels into the chest in a few minutes, so that an otherwise hopeful case, which was non-tubercular of course, was lost by an unfortunate accident. Note here the length of the disease, its destructive yet benign tendency, its amenability to treatment, and the manner in which tuberculosis was prevented from supervening.

A case which I had in Dublin, some years ago, was more fortunate in its progress. The diagnosis was fibroid phthisis, the man a miller, the cavity a large one and on the left side, there was no considerable loss of flesh, and the treatment almost identical with the last case—change of avocation and air, Coghill and carbolic acid inhalations, good food, and tonics with codliver oil. Two months later sputum and cough had vanished, flesh was put on, and a contraction of the thorax over the cavity visible and palpable. I have heard of this man since, that he has had no return of his original symptoms, and that he is still a miller. As the bacillus was not yet discovered at the time I noted this case, I may say that our diagnosis was arrived at empirically but corroborated by the result. The case cannot have been tubercular, because recovery took place; tuberculosis was prevented by the aid of carbolic acid. I do not deny, however, that recovery might have taken place even if this germicide and anti-septic had not been used, but I prefer certainty to chance, and so shall adhere to my respirator in these cases until something better is shown me.

A case of "drunkard's phthisis," which is under observation at present, is rather instructive.

W. C., set. 48, was a labourer in a store where he had much packing to do, and consequently inhaled a considerable quantity of dust. He consumed a great deal of alcohol, and when I first saw him in February of this year he had morning vomiting, &c. Three months ago he had acute catarrhal pneumonia and nearly died, but recovered and returned to work, only to become renewedly attacked a week later; and this time he developed delirium tremens in addition to his other afflictions. Several times I left the house not expecting to see him again alive, and the consultant I called in decided the case as phthisical and hopeless long before. I increased his stimulants, and gave him a respirator as well as cough mixtures and sedatives but no codliver oil. For more than a week he wavered between life and death, when, fortunately, a few warm days intervened and I had him moved into the sun where, to our general surprise, he rapidly picked up, and is now tolerably well, with but slight cough, scanty expectoration, and that of a frothy character. There were no bacilli in this man's sputum, although the case presented at the same time all the symptoms of tubercular phthisis. Such a rapid tran-

sition as took place here could, however, never be mistaken for tuberculosis. The corollary which I herefrom deduce is, that when sudden and rapid improvement takes place in a pronounced case of diagnosed phthisis, we can empirically assume that it is not a case of tubercular character. By using his respirator this man prevented the introduction of tubercle bacilli into his lungs, which were in a terribly fit condition for their reception. It will be interesting to watch the sequel of this case. Another case of a packer, B., at. 33, in a drug store originated through his inhaling dust particles. Tubercle was contracted from associating with a phthisical man in the same department. The patient will die during this cold weather, yet he has been made tolerably comfortable by means of the inhaler which he wears a few hours every day, and the sputum is sweet and liquid; nay further, this man on the brink of the grave, with about a quarter of his lungs left, has never had haemoptysis since. At one time I feared for the wife who had a bad cough since attending on him, with pectoriloquy under the left clavicle and night sweats. She was only recently confined of a healthy male child weighing $8\frac{1}{2}$ lbs. at birth, which she is now suckling. I put her out of the house, and never allow her now to be in her husband's room for a lengthened period, but on every sunny day they are both put into the sun, where they can remain in each other's company until about 3.30 p.m. Mrs. B. has lost all symptoms and is gaining flesh rapidly (Oct. 2). Although it has not been necessary to use the inhaler for various reasons, the physical signs have now disappeared, and she is quite well. I am not very sanguine about her case, however, as she cannot be kept away from her husband, and it would be almost too cruel to separate a dying man from his wife, nay, were I to insist upon this injunction being too strictly enforced another practitioner less scrupulous would be called in to scatter my warnings to the winds. Here is a case of unmistakable infection transmitted by the mother to her child by means of the breast milk:—Mrs. R., at. 34, has had four children, all alive and well. Since the birth of her fourth she had haemoptysis repeatedly, followed by emaciation, sweating at night and chronic cough with characteristic expectoration. She then became pregnant again, and at full term gave birth to a healthy female child, which she nursed herself. Being too poor to engage a doctor, I was not called in until the child was six weeks old. Weaning was then, of course, too late to prevent the mischief which had been already done. In short, the child developed catarrhal pneumonia, followed by symptoms of tubercular meningitis, paralysis of the whole left side of the body, and death from inanition, atrophy, and convulsions. *Post-mortem:* I found

tubercles in the membranes and lungs, and although I did not specifically search for bacilli in the sputum or milk of the mother as it would not have repaid the trouble, I knew that there could be no other possible source of contagion under the circumstances; and now, the stimulus of pregnancy and lactation having been removed, the unfortunate woman is sinking rapidly into the grave. She is too poor to be moved, indeed too poor to purchase an inhaler, so this is indeed a pitiable case, and one which a hospital for consumption would prove of immense value to.

The cases of tubercular phthisis present a melancholy contrast to non-specific cases, and as their course and termination were invariably the same, I need not here enter into them more closely. I have notes of more than 50 such cases, and I need hardly say that as a practitioner I have not time to investigate the sputa of every one of them, most of them being so pronounced that it is superfluous to do so. But my hygienic and antiseptic treatment is always the same, and I have several families under observation in which a solitary case of tubercular phthisis has occurred in which the patient was isolated, strict quarantine observed, and the antiseptic inhalations continued, and have found that life has been prolonged, and that as yet no further case has developed in the particular houses in question. Shortly after Koch's discovery, I was requested by the editor of the *London Medical Record* to write a monthly report upon the progress of antiseptic therapeutics in relation to the new discovery, but after collecting a large amount of material I was obliged to resign my commission, yet have never lost sight of it since, and have kept an observant eye on all that might prove of use on some future occasion, which a recent discussion has afforded at last. The enormity of the subject is appalling, but if I have succeeded in starting even criticism by these few lines I shall feel amply rewarded, and shall not shrink from the avowal of my earnest convictions, justified by high medical authority and supported by experience. A very gratifying letter which I received from Dr. Koch before I left Ireland for the colonies, in answer to some queries which I addressed to him on the subject of the tubercle bacillus, has encouraged me to enter the lists on the question of the contagiousness of phthisis in Australia, adverse criticism, which must be expected, notwithstanding.

The points to establish then in connection with this question will be, first, the particular nature of the complaint, whether it be bacillar or otherwise; second, the communicability of the tubercular or bacillar form of phthisis; third, hereditary transmission or coincidental affection, and lastly, the effects of antiseptic treatment

and disinfection as if for any other infectious or contagious malignant disease, as described by the Board of Health. An investigation into these matters will, I am confident, lead to the inclusion of *phthisis pulmonarum tuberculosa* amongst the category of the most dangerous, contagious, and infectious of all diseases, and to a consequently improved system of treatment and of hygiene, which would gradually lead to its extermination.

In conclusion, I would remind the reader of the fact that statistics shew tubercle to be the most fatal disease yet known, and that one-seventh of deaths from all diseases are due to it; statistics further shew that most deaths occur between the ages of 21 and 40. The experiments of Tappeiner, in Meran, were performed on rabbits, guinea-pigs, etc., and he carried them out by allowing these animals to inhale vapour impregnated with dried pulverised sputa of pronounced phthisical patients, and found them to become tubercled almost invariably after a fortnight. Koch, who succeeded in infecting even rats, which had not hitherto been considered to be inoculable, also proved that infection could only rarely take place from superficial open skin wounds which did not penetrate the subcutaneous cellular tissue, and from the cornea, but that it was necessary for the bacillus to obtain a good foothold in some sheltered part of the body where it could thrive undisturbed. Hence it may be deduced that the reason so many persons display immunity to infection, although exposed to it, is that the bacilli have not been able to penetrate to a good breeding ground, which in the case of persons with some constitutional disturbance, e.g., suppurating glands, catarrhal pneumonia, and so on, is only too easily supplied. The greatest danger of infection lies in the sputum of phthisical patients, which retains its virulence for a long time; and the milk of tubercled cows is another source of danger, which is lost sight of altogether in the scare about cow's milk impregnated with the seeds of typhoid.

One more digression and I have done: One speaker at the recent discussion at the Medical Society's meeting said that carbolic acid never entered the lungs, as it could not be found in the sputa. I was not aware that it had ever been authoritatively stated that such a minute quantity of carbolic acid, as is in the case of a Coghill or Curschman's inhaler, could be inhaled into the substance of the lungs or penetrate the thick masses of mucus and molecular débris in phthisical cavities. All that the substance does is to free the inhaled air of noxious germs, which would set up decomposition if allowed to enter the lungs unpurified. On a healthy lung these micro-

organisms have no effect, although we take them in by millions every second.

I have to express my gratitude to my teacher and friend, Dr. Purser, Professor of the Institute of Medicine in the University of Dublin, for shewing me many of the errors in the popular theories of consumption, for imbuing me with the views I have just expressed, and for teaching me pathological histology, of which there was *no* professor at the great Dublin School of Physic, strange though it may sound out here where students of medicine are more fortunate.

A NOTE UPON SCAVENAGE.

READ BEFORE THE SANITARY SECTION OF THE ROYAL SOCIETY OF N.S.W.

BY J. ASHBURTON THOMPSON, M.D. BRUX., SAN. SCI. CERT. CAMB., DEPUTY MEDICAL ADVISER TO THE GOVERNMENT OF N.S.W.

SCAVENAGE, thoroughly done, is of necessity costly, even when it is in the truest sense economical. It never has paid its own way, and it never can do so. That science should be able to show how something valuable may be reclaimed from matters which, to the individual, are mere *exuviae*, is a hope long since realized; but to expect that waste, accumulated under the artificial conditions of city life, should support that life in any sound commercial sense, appears to me thoroughly unreasonable. Those who flatter themselves they hold this view, may find on consideration, I believe, that it is based upon the general truth that matter is indestructible. At all events they entirely forget to take into account the expenses of collection and carriage, which are unavoidably such as would render articles of much greater acknowledged value not worth handling; and they forget that although their market will fluctuate, they must yet continue uniformly to produce, and at an ever-increasing rate. And, in short, the nett outcome of experience thus far may be summed up in the following axiom:—The community which regards the removal of its domestic refuse as a commercial transaction (in which, therefore, it will not embark considerable sums unless some immediate pecuniary profit can be seen) starts from false premisses and strives to seize a chimera. The true premiss is—not that society must make money out of its necessities, but—that society must preserve health and useful activity as long as may be under the artificial conditions it has itself created. So it comes about that, while removal of refuse matters and expense

are both conditions of good scavenging, its actual cost is but secondary to the urgent necessity for doing it.

Nevertheless, whatever expense within reason might be incurred to secure corporate cleanliness, ultimate profit could be shown to accrue. For dirty districts are unhealthy, and disease costs money; but to cleanse districts is to reduce disease and therefore to save money. The profit is incalculable; not, however, because it is infinitesimal, but for an exactly contrary reason—that it is reverberatory or regenerative. The householder, in estimating the expenses of city life, should set down a rate for scavenging as much as a matter of course as he sets down the rate for water, or for gas, or house rent itself. Yet, just because the profit arising from public cleanliness is not calculable at so many sovereigns per cent. upon so many sovereigns invested; but even more, perhaps, because it does not visibly flow into individual pockets; it may be too much to expect that the average householder should be eager to pay a scavengage rate which does obviously diminish his individual banking account. His judgment of the necessity for such work, and therefore of the amount it is worth his while to pay for having it done, is likely to be fallacious, in so far as it is formed upon the events of daily life as they appear in the obscure and confusing light thrown by half-forgotten memories of inaccurate observations. Experience has shown that even so indisputable a necessary as pure water cannot be made to appear to all the members of a community as so desirable a thing that they will all willingly pay their share of the expense of bringing it to their doors. It is everywhere found necessary to enact that whenever water is led within a certain short distance of a house, the owner shall pay his share of the general expense whether he chooses to take the water or not. How much more likely is the same experience to follow the introduction of systematic scavenging, and how important is it, therefore, that town-councils should everywhere be granted power to strike a scavengage rate!*

Secondary to expense though good scavenging may be, the former is, notwithstanding, a condition which must be reckoned with. Scavenging must be well done; for half done it is a mere covering up of offence—an impudent attempt to cheat nature; sheer waste

* This they do not at present possess in New South Wales. They can levy a sewerage rate under the Municipalities Act, but this cannot be interpreted to include scavenging. Under the Nuisances Prevention Act they can recover from householders any expense incurred in removing night soil from premises; but the 26th section, which defines the nuisances in respect of which proceedings to recover might be taken, cannot, I believe, be interpreted to apply to garbage. The cost of removing this must at present be paid, like that for street cleansing, out of the general rate; and the limit of amount up to which a rate for general purposes may be levied is now far too small to bear the expense of scavenging as well as the other demands it has to meet.

of money therefore. Farther, scavenging is never so well done when it is let at contract as when it is undertaken by the community itself through its aldermen. Bearing these two considerations in mind, and recalling the now well-known fact that the scavenging of cities has never yet been made to pay its way—much less, therefore, to yield a profit—the proposals of certain companies now before the public may well be regarded by rate-payers and aldermen with a coolly critical eye. They all offer profits to their shareholders, one of them venturing to promise so much as 50 per cent. Now I do not for an instant intend to inquire into or dispute the power of these companies to make a profit if their terms of contract are accepted; but whence is it to come? From the manufacture of poudrette? Not entirely, at all events. There is not one of these companies but asks a subsidy in one form or another. Sometimes it appears as a heavy charge for deodorisation; sometimes as a charge—not for collecting the material, whether that be nightsoil or garbage—but for receiving it at the company's works after the labour of collection has been borne by the corporation; sometimes, again, as a heavy charge for collection and disposal. Hence some of the profits. But the chief expense of scavenging lies in the process of collection. Collection being done gratis, disposal may doubtless be made a source of profit. Is there any chance that a company might seek to increase its margin of profit by reducing the expenses of collection to a point at which it would become impossible to do it well? In fine, when all things are considered, is it not pretty clear that councils would best consider ratepayers' interests, both of pocket and health, if they were to undertake this business of scavenging themselves?

CASE OF THYROTOMY.

READ BEFORE THE N.S.W. BRANCH B.M.A.

By CHARLES P. B. CLUBBE, L.R.C.P. LOND.,
M.R.C.S. ENG., HON. SURGEON TO THE
SYDNEY SICK CHILDREN'S HOSPITAL.

THOS. JOHNSON, *et. 4*, was admitted to the Children's Hospital on Nov. 28, 1885, having been brought from Bourke by his mother who gave us the following history:—

Five or six months ago it was noticed that the child's voice altered and became hoarse. Five weeks ago he began to have difficulty in breathing. This has gradually increased up to the present time.

On admission he was found to be a well-nourished child. He was slightly cyanosed. Dyspnoea very marked; considerable sinking in of stomach and ribs at each inspiration; chest resonant all over; respiratory murmur feebly heard; P. 120; T. normal; R. 32; unable to speak above a whisper. We tried to get a look at larynx with laryngoscope but did not succeed.

The next day, Nov. 29, I opened his trachea and put in a silver tube, when the difficulty of breathing at once ceased.

In a few days we were able with the laryngoscope to see that the cause of all the trouble was a warty growth, which we could see peeping up from beneath the vocal cords.

Dr. Hoff, who is interested in this particular branch of surgery, kindly saw the child for me, and he made repeated attempts from time to time to remove the growth with laryngeal forceps, but without success, only very small portions of the growth being removed. The difficulties to contend with in manipulations of this kind on so young a child are enormous. When, after some weeks, it was seen that it was impossible to remove the growth from above, I decided to open the larynx.

On Jan. 20, 1886, Drs. Lovell, Scot-Skirving, and Hoff present, CHCl₂ having been administered through the tracheotomy tube, I exposed the larynx by an incision in the middle line upwards from the opening for the tube. After all bleeding had ceased I put a pointed tenotomy knife into the notch on the upper border of the thyroid cartilages, and cut downwards exactly in the middle line into the crico-thyroid membrane but not through the cricoid cartilage. I was then able to separate the wings of the thyroid by means of two small hooks, which were held apart by one of the gentlemen assisting me. With some small spring forceps I was now able to remove the growth (which was very friable), bit by bit. It is very difficult to judge the exact size of the growth, but I should think what was removed altogether would be about the size of a small hazel nut. There was a good deal of bleeding, which was checked by means of small pieces of sponge dipped in a weak solution of perchloride of iron and then put right into the larynx. I did not put any suture in the larynx, but I closed the external wound with hair-lip pin. During the greater part of the operation, which lasted some time, the child was not under CHCl₂.

For the first week after the operation the child did very well, temp. never going above 100°. After that his temperature went up for a few days, and he got into a low state that gave us a good deal of anxiety, but he soon began to improve.

On July 6 I took the tracheotomy tube out altogether. He breathed through the larynx almost at once, as the opening into the trachea was closed nearly immediately by the granulations that had formed in the wound.

July 12.—He got up for the first time. He now began to speak in a loud whisper.

March 10.—He was discharged, and went home to Bourke. At that time the laryngoscope showed that the growth was beginning to grow again, and the mother was told to bring him back if the symptoms became urgent.

On July 2 he was re-admitted. The mother said that after he got home he could speak in his natural voice, and seemed quite well in every way. In about five weeks he gradually began to lose his voice, and after a time he began to have difficulty in breathing.

As the symptoms were urgent, I opened the trachea at once. The next day he was quite well, sitting up in bed playing with his toys.

July 6.—I again opened his larynx, proceeding exactly in the same way as I did before; but it proved to be a much more difficult operation. Cicatrification had altered the parts, and the landmarks were not so easily made out. Then there was considerable haemorrhage when the thyroid cartilage was split open, which it was impossible to check for a time. When this occurred the child was held head downwards, and the operation was completed while he was in this position for fear of blood getting into the lungs. The growth was removed as on the former occasion. It was quite impossible to see whether it was all gone away. The part of the larynx from where the growth was removed was afterwards touched with modified nitrate of silver. The external wound was closed as before.

The child did remarkably well afterwards, and had no bad symptoms. The tracheotomy tube removed.

July 15.—The boy now speaks in a loud whisper, but is not improving.

I am induced to show him to-night, because if the growth recurs, as it is very likely to do, it is doubtful if we should be able to show him after a third thyrotomy.

NOTE.—It has been found necessary since the above paper was read to operate again, on Sept. 28, when I performed tracheotomy.

Oct. 11.—For the third time I did thyrotomy and removed this warty growth. A strong solution of chromic acid was afterwards applied to interior of larynx.

Oct. 23.—Tube taken out.

Oct. 27.—Boy quite well, running about. Speaks in a loud whisper.

NOTES ON EAR PRACTICE.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH,
B.M.A.

BY WM. A. GILES, M.B. ET CH. M., EDIN.,
OF ADELAIDE, S.A.

THIS evening I wish to read a few notes on three cases of chronic suppurative inflammation of the middle ear which have come under my care since I commenced practice in Adelaide, and which will illustrate well the excellent results to be obtained from the Boracic Acid treatment in many of these affections. I think aurists generally now consider the Boracic Acid treatment, properly applied, in cases of otorrhœa, will produce more rapid cures than any other method, and certainly my experience makes me regard it very favourably. The marked benefit often ensuing after the use of Boracic Acid is supposed to be brought about partly by its antiseptic properties and partly because it acts as a bland soothing application to the inflamed mucous surfaces keeping them dry and diminishing irritation.

The first case I have to report is that of a small delicate boy, *æt.* 10 years, who was brought to me in June last complaining of a purulent and very offensively smelling discharge from both ears, the right being worse than the left. He had suffered thus since an attack of measles which he had 4 years previously. The discharge was always present in greater or less quantity, and latterly his hearing had become much impaired. He had tried many methods of treatment, but none gave him any permanent relief. He was occasionally seized with attacks of ear-ache, but they were not very severe and passed off in a few days. After such attacks the discharge was always more abundant and the deafness increased. He told me he was obliged to change the pellets of cotton wool, which he always kept in his ears, several times a day, as they became so quickly saturated.

Objective Examination.—I found the canal of the *right* ear nearly full of a thick white fluid of a creamy consistence, which I removed by syringing, and could then make out the condition of the middle ear through the speculum. The membrane tympani was almost completely absent, only a thin edge could be made out in the upper and posterior part. The mucus membrane over the promontory was much thickened and granular. The stapedius could be seen, but there was no sign of the long process of the malleus. This bone was either entirely absent, or it had been drawn out of sight by the action of the tensor tympani muscle, which was no longer counteracted by the presence of the tympanic membrane.

Left Ear.—Here, too, the view was obstructed by the external auditory canal being blocked up by a mixture of pus, epithelial scales, and debris, which I was obliged to remove. The tympanic membrane in this case had a perforation in the lower and anterior part, and the membrane covering the short and long processes of the malleus was red and injected.

Treatment.—In this case, as in the subsequent ones, I employed the Boracic Acid treatment in every detail.

Right Ear.—I carefully cleansed the parts by syringing with a warm solution of corrosive sub-limate (1—2000), after which I dried the canal thoroughly with absorbent cotton wool. Politzer's method of inflating the middle ear through the Eustachian tube was then resorted to, in order to drive out any purulent secretion that might remain, and the ear once more carefully dried. I next with an insufflator blew into the ear a large quantity of a very finely-powdered Boracic Acid, and plugged the meatus with cotton wool. I gave the boy's mother a weak solution of carbolic acid, with directions to wash his ears out with it as soon as the discharge again made its appearance, and after syringing and drying to blow in some of the powder.

Left Ear.—The same treatment. In two days he returned and told me the discharge had been wonderfully reduced in the right ear, but the left ear was in much the same condition. To remedy this I washed out the middle ear by means of a thin India-rubber tube introduced through an Eustachian catheter, and in this way I removed a quantity of thickropy pus. I also pulled out through the perforation several strings formed of inspissated pus, mucous, and epithelial scales matted together. The Boracic Acid treatment was continued, and in a fortnight the discharge had entirely ceased in both ears. The granular condition of the mucous membrane was speedily reduced by the application of chromic acid fused on the end of a probe. I carefully noted his hearing power from time to time, but, unfortunately, have mislaid the record. I can, however, state that the hearing in the left ear improved to a very great extent, and when I last saw him he could hear my whispered voice at a distance of 10 feet. The first day he came to me I had to shout at him to make him hear at all.

I gave the syrup of the iodide of iron internally the whole time he was under treatment.

CASE NO. II.

M.N., *æt.* 28, domestic servant, consulted me in September last. She had then been about 5 years in the colony. When 12 years of age she had scarlet fever, and on approaching convalescence an abscess formed in the ear, which, after

causing her great agony for some days, burst suddenly and gave her immediate relief. The matter continued to come from the ear and the quantity increased, so she applied to a doctor in Scotland, where she then resided, who evidently considered the condition serious. At any rate the patient's statement is, that he told her not to endeavour to check the discharge, for if she did she would go blind! A strange prognosis truly!!

After this she took no measures to cure her disease, and the running from the ear continued with varying degrees of intensity. Three months ago the quantity increased, and became very foetid. As weeks went by the bad odour became more marked, and people noticed it directly she entered a room. On this account her mistress insisted upon her seeking medical aid.

I give the history at length to show how long a person will put up with such a state of things without taking proper steps to obtain relief, and also to call attention to the strange advice given by some people who practice medicine.

The patient's condition when I saw her was not very promising, and I was afraid of some necrosis having taken place. She was very anaemic and complained of loss of appetite, general weakness, and lassitude. The discharge was copious and of a reddish colour, but did not convey any gritty sensation when rubbed between the fingers. The odour was abominable, and of late she had had a dull aching pain behind the ear.

Objective Examination.—Right ear.—The external auditory canal was almost entirely filled with a large red mucous polypus. I could pass the probe down the whole length of the canal and freely all round the growth, so came to the conclusion that the polypus was growing from the promontory.

Hearing distance.—Right ear.—Neither watch nor tuning fork could be heard on contact, nor could she hear my voice when raised to the highest pitch. Left ear.—The external auditory canal and membranæ tympani were both quite normal; hearing power very acute.

Treatment.—Iron internally, and occasional purgation. I managed to remove nearly the whole polypus at one sitting with a Wilde's snare, without causing the patient much discomfort. The next morning what remained was easily removed, and an alcoholic solution (1-4 parts) was given, to be used twice a day to dry up the stump. This was continued several days. Politzer recommends such a solution in certain cases, and on this occasion I found it very beneficial. After this I carefully carried out the Boracic Acid treatment, with the result that in three weeks from the time I first saw her the discharge had quite ceased and

the thickened congested mucous membrane looked comparatively healthy. I had the opportunity of examining the ear a few weeks ago, when she told me she had had no discharge nor any discomfort since being treated by me, nor was there any sign of the polypus returning.

CASE NO. III.

The third case is that of a boy aet. 8, who was brought to me with a history that since he was 18 months old he had had a discharge from the right ear. A similar discharge came on from the left ear about 12 months ago, after an attack of ear-ache. Very little odour was noticeable, but the running from both ears was considerable. He was so deaf that I had difficulty in making him hear at all.

Objective Examination.—Right ear.—After clearing out the external auditory canal with the aid of my syringe, I was able to obtain a view of the membranæ tympani. I found a large perforation in the lower and anterior part, and marked pulsation was to be observed in the fluid in the tympanic cavity. The membrane over the short process of the malleus was inflamed. Left ear.—Here a perforation existed in Schrapnell's membrane which discharged pus in small quantities. The rest of the membrane appeared normal.

Hearing distance.—

Right ear.—T.F. = contact.

Watch = contact.

W.V. = nil.

Left ear.—T.F. = 6 in.

Watch = 4 in.

W.V. = nil.

Throat.—The tonsils were somewhat enlarged, and follicular pharyngitis present. By means of cocaine and the rhinoscopic mirror, I obtained a good view of the naso-pharynx and the orifices of the Eustachian tubes, and found the whole mucous membrane much inflamed and thickened. The turbinated bones were not hypertrophied.

Treatment.—I canterised the throat freely, and afterwards used pigments of Tr. ferri, perchlor., and glycerine; also tannic acid and glycerine. Boracic Acid treatment for both ears. In a week after commencing treatment the discharge had stopped entirely in the right ear. The left ear did not improve, so I washed out the tympanic cavity with an India-rubber tube through the perforation, and succeeded in removing several cheesy masses from the middle ear. The Boracic Acid powder was continued, and at the same time Siegle's pneumatic speculum was used to help to remove secretion from the tympanum by suction. The throat rapidly improved, and air passed with greater ease through the Eustachian tubes. A month after I first

saw the boy there was absolutely no discharge, and the hearing distance was :—

Right Ear.—T. F.	= 6 in.
Watch	= 6 in.
W. V.	= nil.
Left Ear.—T. F.	= 2 ft.
Watch	= 2 ft.
W. V.	= 6 ft.

General treatment was carefully carried out—cod-liver oil, iron, nourishing diet, fresh air, &c.

Remarks.—These cases were all admirably suited to the Boracic Acid treatment, and the results obtained were most satisfactory, but I have had several cases of purulent disease of the middle ear which were not in the least benefited by it, and I had to have recourse to other methods. Cases least likely to respond favourably to the treatment I am advocating are :—1. When the disease is associated with phthisis or marked scrofula. 2. When disease is present in the mastoid cells. 3. When the perforation is very small. 4. When caries or necrosis exists. In all other cases of otorrhœa I think the treatment should be commenced with Boracic Acid, applied as I have described.

PROCEEDINGS OF SOCIETIES.

QUEENSLAND MEDICAL SOCIETY.

AFTER an interval of three years the above Society held a meeting at the Brisbane School of Arts on Monday, October 26, the members present being Drs. Taylor, Rendle, Bancroft, Little, Lyons, Campbell, and E. O'Doherty.

The following new members were unanimously elected :—Drs. Hill, Owens, Love, McNeely, Neill, Gibson, Tilston, and W. S. Byrne.

Dr. Love read a valuable paper on "Progressive Pernicious Anæmia," which dealt at length with the history, pathology, diagnosis, and treatment of that disease.

A vote of thanks having been carried by the meeting, the election of officers for the ensuing year was proceeded with. Dr. Bancroft was elected President of the Society ; Dr. Rendle, Secretary and Treasurer ; Drs. Taylor, Love, and W. S. Byrne, members of the Council ; and Dr. Gibson, Librarian.

It was decided that the meetings of the Society should be held on the second Tuesday in every month, and after some discussion on business matters, the meeting closed.

NEWCASTLE (N.S.W.) MEDICAL SOCIETY.

A MEETING of the medical profession of the city and district of Newcastle was held at the Board room of the Newcastle Hospital on the 7th October, at which it was resolved that a local Medical Society should be formed. A code of rules was read, discussed, and adopted, and the following gentlemen were enrolled as original members of the "Newcastle Medical Society":—Drs. W. C. Ashe, G. Wiston Baker, J. L. Beeston, J. Bonnefin, John Harris, C. Hedley, S. E. Herbert, H. H. Massey, C. W. Morgan, J. B. Nash, W. H. Rogers, J. J. Stapleton, and R. H. Treloar. Dr. C. W. Morgan was elected

President for the first year, and Dr. W. C. Ashe, Hon. Secretary and Treasurer.

The opening meeting of the new Society will be held at an early date.

SANITARY SECTION OF THE ROYAL SOCIETY OF N. S. WALES.

THE general meeting of this Society was held at the Society's House, Elizabeth-street, Sydney, on October 19. The chair was occupied by Sir Alfred Roberts, Kt.

An interesting paper on the subject of "The Sanitary Condition of some portions of the Eastern Suburbs" was read by Dr. Quaife, in which the writer referred to the deficiency of the drainage system at the eastern end of the city. Dr. Quaife cited instances in which persons had been seized with typhoid as a consequence of their living in ill-drained houses. His experience of typhoid in Woollahra made him feel sure that the disease could be inhaled from defective drains. Dwelling-houses should, he stated, be kept separate from all drains, and advantage should be taken of the Bondi sewer as soon as it is finished, in order that the drainage of their dwellings might be carried off. He thought the great questions of water-supply and sewerage should be managed for the whole of the metropolitan area (within certain limits) by a representative board, whose members should be elected by the different municipalities, some members to be appointed by the Government ; scientific men should also have a seat on the board, which should have the power to levy taxes, to inspect premises, and to carry out all necessary work.

Dr. J. Ashburton Thompson contributed "A Note upon Scavenging," i.e., the cleansing of public dwellings by public authority, which will be found elsewhere.

Dr. Thompson also read a paper entitled "Notes on the Recent Outbreak of Smallpox on the Oceanien" in which he referred at length to the outbreak of smallpox which occurred on the French steamship some time ago, and detailed the action taken in regard to the outbreak at the several ports at which the vessel touched. He also referred to the fact that the course pursued in Sydney in the case of the Oceanien was essentially different to that which had been pursued under the very same circumstances, and only a day or two previously, at Melbourne. At that port the vessel was regarded as clean, and she was admitted to free pratique ; here, she was regarded as infected, and was detained in quarantine for some days. He declared that he could not understand why the steamer was regarded as clean in Melbourne and given free pratique, and he specially condemns the health authorities at Mauritius. There seems to have been, he said, a dereliction of duty along the whole line. The case forcibly illustrates the necessity for federal quarantine ports.

Discussion ensued after the reading of the paper, and the writers of the same were thanked for the information they had given to the meeting.

SYDNEY UNIVERSITY MEDICAL SOCIETY.

THE fifth monthly meeting of the Sydney University Medical Society was held on Friday evening, Oct. 29th, in the theatre at the Prince Alfred Hospital. Dr. Graham, the president, occupied the chair. There were forty members present. The minutes of the previous meeting were read and confirmed. The chairman then introduced to the meeting the Rev. Principal Kinross, D.D., who read a paper on "The Relation of the Medical Profession to Culture." The following gentlemen afterwards spoke on the subject :—Dr. Goode, Mr. Rutledge, B.A. (who proposed a vote of

thanks to Principal Kinross), Mr. Hester (who seconded it), Mr. Hollis, Mr. Nolan, Dr. McAlister, Dr. Wood, and the chairman, who thanked the Rev. Principal Kinross on behalf of the Society. The Principal suitably replied. The following business was also done:—Mr. Bancroft proposed, and Mr. White seconded, that the following journals be subscribed to by the Society—*Lancet*, *Practitioner*, *British Medical Journal*, *Australasian Medical Gazette*, and *Speculum*. A committee was elected to make arrangements for the social meeting on Dec. 9th. The meeting then terminated.

REVIEW.

The Diseases of the Prostate—Their Pathology and Treatment. By SIR HENRY THOMPSON. Sixth Edition. London : J. & A. Churchill, 1886.

This brilliant and accomplished surgeon has given to the profession a sixth edition of his work of the Prostate containing a *résumé* of all that is known of the gland and of its diseases up to date.

Distinguished in many walks of art it may be truly said of Sir Henry Thompson, *nihil tetigit quod non ornari*. The immense opportunities he has enjoyed, and the laborious care he has spent on the study of the diseases of the bladder and its adjacent organs have placed any production of his on the subject beyond the pale of criticism.

The harvest of this author's life-study is golden grain to the reaper, and to the surgeon, constantly called upon to deal with diseases and especially senile enlargement of the Prostate, this book is a safe and clear guide. The topographical and structural anatomy of the Prostate is exhaustive, and is based on facts obtained by 194 dissections of the gland. The minute anatomy displays marvellous research.

In the treatment of acute inflammation of the Prostate in young subjects local bleeding to the extent of eight ounces followed by warm hip baths, is recommended. The great importance of diagnosis of enlargement, together with the various conditions which give rise to it, is strongly insisted on, and a very useful description of the normal gland as felt by the "tactus" given.

In the treatment to obviate the results of urinary obstruction by an enlarged Prostate, Sir Henry Thompson considers "a catheter, the end of which is slightly turned up, or technically speaking, 'coudée,' 'elbowed,' generally the best."

He also dwells strongly on the necessity of having ready to hand several instruments by all who rely upon mechanical aids for the act of micturition. Travellers should remember this. "Such terrible consequences result from neglect of these precautions that their mention is not less necessary than any other part of the details of treatment."

It is most encouraging to find that "the cases of urinary retention from prostatic enlargement which cannot be relieved by the introduction of a catheter of some kind, are extremely rare." Such is the opinion of one who is a "master-hand." Sir H. Thompson has only had occasion to puncture the bladder for prostatic retention four times in his life.

Opening of the bladder above the pubis and removal of urine by perineal incision are fully discussed. This latter operation, known as "Digital Exploration," has been somewhat extensively practised in this colony already by an able surgeon, one of Sir Henry's pupils, and is an efficient means of affording very considerable relief to some of the worst of cases.

Cancer, tubercular diseases and concretions, and calculi form other chapters of this splendid contribution to the Surgical Literature of the Bladder.

OBITUARY.

WALTER FAWKES MACKENZIE,
L.R.C.P., M.R.C.S.E.

THE medical profession of New South Wales has sustained another heavy loss in the death of Dr. Walter F. Mackenzie, one of the leading practitioners in Sydney, who died at his residence, Lyons' Terrace, Hyde Park, on October 14, after a short illness. The deceased gentleman was born in Lancashire, and took the degrees of M.R.C.S. Eng. and L.S.A. Lond. in 1859, and that of L.R.C.P. Edin. in 1861. He arrived in N. S. Wales in 1862, and settled in the first instance at West Maitland, where he soon obtained a very large practice, under the pressure of which his health gave way. He retired for a time to Wallerawang, in the Blue Mountains, where he had a property, and on regaining his strength resumed his profession in Sydney, where he enjoyed a large practice up to the time of his death. In 1876 he was appointed Chief Medical Referee to the Australian Mutual Provident Society, the duties attached to which position he discharged to the entire satisfaction of the board. The work was onerous, involving the personal examination of from 400 cases annually, and the revision of all the medical reports from the country. He had also been a member of the N. S. W. Medical Board since April last.

His loss will be severely felt, not only among his own immediate family circle, but also by a large number of friends by whom he was much esteemed for his genial and cheerful disposition, his generosity, and uprightness.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, NOVEMBER 15, 1886.

EDITORIALS.

NEW MEDICAL SOCIETIES.

SINCE our last issue we have received a communication from the Secretary of the newly-formed Medical Society of Newcastle, N.S.W. This Society has been established in that city with a view of promoting the well-being of the profession in that district. Monthly meetings are to be held, at which papers of interest will be read. Dr. Cosby Morgan has been chosen the first President.

The Queensland Medical Society, though nominally an old one, is practically also a new body, no meeting having been held for three years until October 26th, when a fresh departure was made in Brisbane. A paper was read, officers chosen, and several new members elected.

We congratulate our brethren in these places on their action, for we think that local societies are likely to be of practical use in promoting the prosperity and amity of the profession, and they will make a commencement towards what we are of opinion must soon come, viz., the establishment of an Australasian Medical Society formed of such Societies when confederated. We are of opinion that the best interests of medicine in this part of the world would be better conserved by such a Society, with amicable relations to Societies of a similar character in the old world, than by continuing the connection with the British Medical Association, which is not of much practical benefit, and has been found more or less a clog on the proceedings and business conduct of its branches in Australia.

THE NEW MEDICAL ACT OF THE UNITED KINGDOM.

By the Amending Medical Act, recently passed by the Imperial Parliament, provision is made in the second part of it for the recognition of the medical schools in the various British possessions as bodies whose diplomas may be accepted as entitling the possessors to registration in the United Kingdom as medical practitioners. It is necessary that the claims of any colonial medical school to be so recognised shall be brought before the home authorities, when Her Majesty, by order in Council, may declare that the colony so applying shall be deemed one to which this part of the Act shall apply. It is provided that only such colonies or countries which extend the like privileges to medical practitioners qualified in the United Kingdom should receive this benefit. Application for recognition has been, or is to be made by the Universities of Melbourne and Sydney, whose diplomas are as good a proof of competence for the practice of medicine as that of the majority of British schools. We now append that portion of the Act of interest to our readers:—

PART II.

COLONIAL AND FOREIGN PRACTITIONERS.

11. *Registration of colonial practitioner with recognised diploma.*]—On and after the prescribed day, where a person shows to the satisfaction of the registrar of the General Council that he holds some recognised colonial medical diploma or diplomas (as hereinafter defined) granted to him in a British possession to which this Act applies, and that he is of good character, and that he is by law entitled to practise medicine, surgery, and midwifery in such British possession, he shall, on application to the said registrar, and on payment of such fee, not exceeding five pounds, as the General Council may from time to time determine, be entitled, without examination in the United Kingdom, to be registered as a colonial practitioner in the medical register;

Provided that he proves to the satisfaction of the registrar any of the following circumstances:—

- (1.) That the said diploma or diplomas was or were granted to him at a time when he was not domiciled in the United Kingdom, or in the course of a period of not less than five years, during the whole of which he resided out of the United Kingdom; or
- (2.) That he was practising medicine or surgery or a branch of medicine or surgery in the United

Kingdom on the said prescribed day, and that he has continuously practised the same either in the United Kingdom or elsewhere for a period of not less than ten years immediately preceding the said prescribed day.

12. Registration of foreign practitioner with recognised diploma.]—On and after the said prescribed day, where a person shows to the satisfaction of the registrar of the General Council that he holds some recognised foreign medical diploma or diplomas (as hereinafter defined) granted in a foreign country to which this Act applies, and that he is of good character, and that he is by law entitled to practise medicine, surgery, or midwifery in such foreign country, he shall, on application to the said registrar, and on payment of such fee, not exceeding five pounds, as the General Council may from time to time determine, be entitled, without examination in the United Kingdom, to be registered as a foreign practitioner in the medical register;

Provided that he proves to the satisfaction of the registrar any of the following circumstances:—

- (1.) That he is not a British subject; or
- (2.) That, being a British subject, the said diploma or diplomas was or were granted to him at a time when he was not domiciled in the United Kingdom, or in the course of a period of not less than five years, during the whole of which he resided out of the United Kingdom; or
- (3.) That, being a British subject, he was practising medicine or surgery, or a branch of medicine or surgery, in the United Kingdom on the said prescribed day, and that he has continuously practised the same in the United Kingdom or elsewhere for a period of not less than ten years immediately preceding the said prescribed day.

13. Medical diploma of colonial and foreign practitioner whom deemed to be recognised.]—(1.) The medical diploma or diplomas granted in a British possession or foreign country to which this Act applies, which is or are to be deemed such recognised colonial or foreign medical diploma or diplomas as is or are required for the purposes of this Act, shall be such medical diploma or diplomas as may be recognised for the time being by the General Council as furnishing a sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practice of medicine, surgery, and midwifery.

(2.) Where the General Council have refused to recognise as aforesaid any colonial or foreign medical diploma, the Privy Council, on application being made to them, may, if they think fit, after considering such application, and after communication with the General Council, order the General Council to recognise the said diploma, and such order shall be duly obeyed.

(3.) If a person is refused registration as a colonial or foreign practitioner on any other ground than that the medical diploma or diplomas held by such person is or are not such recognised medical diploma or diplomas as above defined, the registrar of the General Council shall, if required, state in writing the reason for such refusal, and the person so refused registration may appeal to the Privy Council, and the Privy Council, after communication with the General Council, may dismiss the appeal or may order the General Council to enter the name of the appellant on the register.

(4.) A person may, if so entitled under this Act, be registered both as a colonial and a foreign practitioner.

14. Separate list of colonial and foreign practitioners in medical register.]—The medical register shall contain a separate list of the names and addresses of the colonial practitioners, and also a separate list of the

names and addresses of the foreign practitioners registered under this Act; each list shall be made out alphabetically according to the surnames; and the provisions of the Medical Act, 1858, relating to persons registered under that Act, and relating to the medical register and to offences in respect thereof, shall, so far as may be, apply in the case of colonial and foreign practitioners registered under this Act and of the said lists of those practitioners, in the same way as such provisions apply in the case of persons registered under the said Medical Act, 1858, and of the register as kept under that Act.

15. Medical titles of colonial and foreign practitioners.]—On and after the appointed day it shall be lawful for any registered medical practitioner who, being on the list of colonial or of foreign practitioners is on that day in possession of or thereafter obtains any recognised colonial or foreign medical diploma granted in a British possession or foreign country to which this Act applies to cause a description of such diploma to be added to his name in the medical register.

16. Registration of foreign degrees held by registered medical practitioners.]—On and after the appointed day it shall be lawful for any registered medical practitioner who, being on the medical register by virtue of English, Scotch or Irish qualifications, is in possession of a foreign degree in medicine, to cause a description of such foreign medical degree to be added to his name as an additional title in the medical register, provided he shall satisfy the General Council that he obtained such degree after proper examination and prior to the passing of this Act.

17. Power of Her Majesty in Council to define colonies and foreign countries to which this part of the Act applies.]—(1.) Her Majesty may from time to time by Order in Council declare that this part of this Act shall be deemed on and after a day to be named in such Order to apply to any British possession or foreign country which in the opinion of Her Majesty affords to the registered medical practitioners of the United Kingdom such privileges of practising in the said British possession or foreign country as to Her Majesty may seem just; and from and after the day named in such Order in Council such British possession or foreign country shall be deemed to be a British possession or foreign country to which this Act applies within the meaning of this part thereof; but until such Order in Council has been made in respect of any British possession or foreign country, this part of this Act shall not be deemed to apply to any such possession or country; and the expression "the prescribed day" as used in this part of this Act means, as respects any British possession or foreign country, the day on and after which this part of this Act is declared by Order in Council to apply to such British possession or foreign country.

(2.) Her Majesty may from time to time by Order in Council revoke and renew any Order made in pursuance of this section: and on the revocation of such Order as respects any British possession or foreign country, such possession or foreign country shall cease to be a possession or country to which this part of this Act applies, without prejudice nevertheless to the right of any persons whose names have been already entered on the register.

18. Amendment of 21 and 22 Vict. c. 90. s. 36., as to medical officers in ships.]—Nothing in the Medical Act, 1858, shall prevent a person holding a medical diploma entitling him to practice medicine or surgery in a British possession to which this Act applies from holding an appointment as a medical officer in any vessel registered in that possession.

THE SANITARY CONDITION OF NEW-CASTLE (N.S.W.)

THE neglect of the Town Council of that city as to its sanitary condition is most lamentable, and is a striking example of the unfitness of municipal bodies to be entrusted with any discretion in the conduct of health matters. The state of the town is a standing menace to the health of the Australian colonies, for as one of the most frequented shipping ports it has a special liability to the introduction of disease, which, if once introduced there, would find such a suitable nidus for its propagation, that the effect of the importation of the germs of cholera or yellow fever is fearful to contemplate. We append the report of Dr. Ashburton Thompson, the Deputy Medical Adviser to the N.S.W. Government, with the minute of his senior officer, Dr. MacLaurin, in submitting it to the Colonial Secretary. The attention of the Government was called to this important matter by the sanitary association recently formed at Newcastle, and the usefulness of this society needs no other proof. As is usual with municipal bodies when their action is adversely criticised, the evils are denied, and the doctors who have moved in the matter are bluntly accused of being mere alarmists by some of the town councillors, who seem to forget that the action of medical men in bringing their laches in sanitary matters under public notice is highly disinterested, for such neglect, if continued, would eminently tend to increase their pecuniary gain. Dr. Ashburton Thompson's report is as follows :—

"Health Department, N.S.W.

"17th August, 1886.

"The Deputy Medical Adviser to the Medical Adviser to the Government.

"Sir,—In accordance with your minute, I visited the borough of Newcastle on the 2nd August.

2. "I visited the Mayor (Mr. Thorne), Alderman Thurlow, and the town clerk, and conversed with them. I also conferred with Drs. Cosby Morgan and Ashe, the former of whom is president of a sanitary association lately organised by the inhabitants of the borough and the medical profession; the latter took me to various parts of the city, and showed me many of the nuisances complained of.

3. "The district to which my attention was called was the borough only. Its area is small but thickly populated. It is bounded on the south by the municipality of Merewether, on the west by that of Hamilton, on the north-west by that of Wickham, and at other points by the harbour and ocean, and a large paddock belonging to the Australian Agricultural Company. Its conformation is peculiar, in that about three-fourths of it consists of low-lying ground, of which much is scarcely above high-water mark or actually below it, while the rest is made up of very steep hills and broken ground. There are no sewers, except a few which convey storm water only, and which discharge direct into the harbour; the water reaches these

through very large sumphs (measuring from five to eight feet by two or three), which I was told are a source of serious nuisance in warm weather. They are used by neighbouring inhabitants as garbage receptacles. A water supply was obtained last year from the Hunter, above Maitland; but the town council has not yet acquired control over it, handing over all collected revenue to the Government for the present. Thus while much slop-water is made, there are provided no means of carrying it away. Most of the houses have cesspits, many have wells also. But the number of each is unknown, no such survey having ever been conducted as would place the council in possession of the domestic arrangements of the houses within their jurisdiction, essential as it is to the proper performance of the chief duty to which they are appointed. 110 pan-closets were dealt with during 1885, but it is not certain that this is the whole number existing; if there are more in use, the rest must be emptied by the persons to whom they belong, and the contents therefore buried around their houses in all probability. From cesspits 45,156 feet of soil were removed during 1885; but the number of pits cannot be calculated from this figure because very many are mere holes in sandy soil, which allows so much of the contents to drain away as renders it unnecessary to employ them by hand. The total quantity of soil thus removed during last year amounts to about 1700 tons. This weight is made up of fluids and solids. The population of the borough having been 8986 at the census of 1881, the present population will be much under-estimated if for convenience it be taken at 10,000. 10,000 people produce per diem two tons four cwt. of solid excrement, and eight tons sixteen cwt. of fluid excrement; making a total for a year of 365 days of 4015 tons. Of this it appears that about 1700 tons are collected; what becomes of the balance consisting of 2315? As the city is unprovided with sewers it must lie about the neighbourhood of the houses in which it is produced, polluting air, soil, and water. Until four or five years ago, collected nightsoil was buried in a small paddock adjoining the hospital, which is itself in the heart of the town. About that time the hospital committee prevailed upon the council to find another tip, on account of the danger in which they believed the Hospital inmates were placed, the townspeople in general not having objected to the council's extraordinary proceeding as far as I could ascertain. The new site was found on the race-course, where, of course, there is a considerable extent of open ground, but which is, nevertheless, surrounded by houses at no great distance. An area of two acres was enclosed, and the soil more or less carefully trenched in; and when the patch was used up, the fence was transferred to another part, and this process was repeated over and over again. A short time ago the medical men of Newcastle drew attention to the exceeding prevalence of typhoid fever in the houses and neighbourhood around the racecourse, and in consequence, the manager for the company to whom the land belongs gave the council a month's notice to cease tipping there, with the avowed object of compelling them to deal effectually with the question of scavenging, which they had so long and so persistently neglected. But the council showed that they were not to be thus coerced into decency; they found a way out of the dilemma in which they were apparently placed, which could only seem open to entirely unscrupulous persons. They merely began to tip the soil again in the paddock already referred to—next the hospital, and in the heart of the city. There it is now being shot. The only recognised tip for house refuse or garbage which has ever existed, is behind, and in close proximity to the hospital, which, in consequence, is afflicted with a

veritable plague of flies during hot weather, and by abominable smells. About two years ago the late medical adviser visited and reported upon this garbage tip, and the Colonial Secretary warned the council to cease to use it. But no heed was paid; the order was regarded by a majority of the council as *ultra vires*, I believe, and at all events tipping was continued there. Although, however, as this was the only recognised tip, it has never been the only place in which garbage has been deposited. On the contrary, this putrid refuse has always been regarded in Newcastle as quite proper material to use to reclaim swampy and irregular land for building purposes, and to make roads. In conversation with me, the mayor expressed the opinion that garbage, although it consists of every description of organic filth in a state of putrescence, can do no harm to man, even when it is used as the foundation of houses, and that doctors, in maintaining the contrary, jump to a conclusion, as (he said) doctors are so prone to do. I do not feel that much hope of voluntary amendment can be reasonably entertained of a body whose elected chief can coolly utter such opinions as these. Probably he would not venture to express them thus boldly unless he were aware that many of the townspeople share them with him, and I can scarcely doubt that the criminal capacity of some of the landholders has hitherto stood in the way of every plan for effectually destroying or removing to a distance the garbage of this city. The so-called land they hold is often useless in its natural condition for building or any profitable purpose, either from its depression below the tide level, or its extreme irregularity, or for want of approaches. Several factories and mines produce heaps of slag and waste with which such ground might be well and safely made good; but owners would have to pay the cost of cartage. But the garbage they can not only get for nothing, but carried to their properties without cost. They therefore notify the council that garbage may be tipped on their land, and the council who are obliged to remove from the houses producing it, and who profess themselves unable to devise any means of disposing of it, are doubtless thankful for the accommodation. In short, the bargain suits both parties far too well not to be entered into as a matter of course. The council, by their long-continued and consistent action in this matter, have shown themselves unable to understand that, in pursuing a course which must inevitably lead (as I am informed it has led) to a vast amount of unnecessary sickness and avoidable death, they are striking the deadliest blow at the prosperity of their district; and landholders who, to make money, can resort to so filthy an expedient as this, are clearly open to no argument which interferes with their own petty interests.

Speaking of the city generally, I may say that I saw that garbage is removed from the neighbourhood of the houses which produce it, in a slovenly and perfunctory manner, but only to be accumulated in stinking putrid heaps under or close to other houses. I observed that if the council should at any time begin to make an earnest attempt to cleanse the city, they would probably be obliged, as a preliminary step, to take out nearly as many summonses as there are householders.

4. "The revenue expended by the town council is about £20,000 a year, and increasing.

5. "You will have observed the long delay in presenting this report. At my interview with the Mayor and Town Clerk I asked the latter many essential but simple questions, which he said, not unreasonably, that he could not then answer, but would answer if I wrote and transmitted them to him. This I duly did the next day. Having received no answer I wrote again on the

14th, and in reply I was informed on the 17th that the Mayor considered I should have addressed the council and not the Town Clerk. As I had pursued the usual course in thus addressing the Town Clerk I must conclude that the information is covertly refused by the council.

The most important question, however, I was able to get answered through another source. In reply to my inquiry how many summonses for nuisance were taken out by the Inspector of Nuisances for the year 1885, the Inspector-General of Police has informed you that but three against three persons were issued.

6. "I have much pleasure in drawing your attention to the formation recently of a Sanitary Association in Newcastle, which is composed of all classes of inhabitants, and which includes all the medical men. Under the excellent rules devised by the President, Dr. Cosby Morgan, and adopted at a recent meeting, provision is made for enrolling all those who may wish to join, but who are not able to pay any subscription. I believe too much praise cannot be given to the perseverance and energy which have led to the formation of this association, nor to its organisation. A select working committee has been appointed, and counsel retained; but the opportunity given to the humblest members of the community to enrol themselves members is a most useful and promising feature, based as it is upon the principle that in sanitary improvement of communities, education of individuals is the corner stone. You will thus infer that the population do not all of them approve of the neglect of the council, which I have attempted to indicate here, and that many of them feel after long continued remonstrance and appeal, that they are in reality in the grasp of an irresponsible body. And that body believes that it is irresponsible and uncontrollable, as its action with regard to the minute of a former Colonial Secretary, and, on the present occasion of withholding information, sufficiently testify.

7. "I consider it my duty to record my opinion that Newcastle being a very large shipping port, it should be guarded with especial care against the introduction of epidemic disease; and that having examined the peculiarities of the site of the city, and having witnessed the filthy state into which it has been allowed to fall, were either cholera or yellow fever introduced, no measures could be devised which would save the inhabitants from the most disastrous spread of those diseases.

"Were Newcastle attacked, not Sydney alone, but the whole country would be in the most imminent danger; and even if only a scare arose on account of the nature of its traffic, and its connection with the remotest parts of Australia, the loss and damage to trade would be immense.

8. "Considering all the circumstances of this case, that is to say, the filthy state of the city; the vast importance to the interests of the whole colony of keeping it free from epidemic disease; the stolid indifference to the wishes and remonstrances of the wiser and more intelligent citizens shown by the council; the defiant attitude assumed by the council on a former occasion towards the Government; the well-planned efforts which are now being made by the medical profession and the more prudent members of the community to emancipate themselves from the thrall in which the council has hitherto held them, and the appeal to the Government which they have now made for assistance in their endeavour; and considering farther that the powers conferred upon the council by the Nuisances Prevention Act, 1875, are sufficient to enable them to improve the state of the city very materially, if only they were exercised, I suggest that you should advise the honorable the Colonial Secretary that it has

become necessary to warn the council that if within four months they have not (1) exercised to the full their powers under the Nuisances Prevention Act to enforce the substitution of earth or rather pan-closets for cesspits ; (2) to prevent the deposit of garbage and night-soil upon places within the borough ; (3) freed houses and streets from existing sources of nuisance ; (4) devised and adopted a scheme whereby their city may not only be effectually scavenged, but the collected refuse be so disposed of that it shall neither be a danger nor a nuisance to their own or to other people ; the Executive will exercise the powers they enjoy under section 8 of the said Act. And in order that the steps taken by the council to effect the indicated amendment may be speedy and effectual, the council should be invited to confer with you from time to time, and the city be brought under your inspection.—I have, etc.,

"(Signed) J. ASHBURTON THOMPSON,
"Deputy Medical Adviser.

"The Medical Adviser to the Government."

"Board of Health Office,
"127 Macquarie-street,
"Sydney, 31st August, 1886.

"In submitting for the consideration of the hon. Colonial Secretary the attached report by the Deputy Medical Adviser on the sanitary condition of the borough of Newcastle, I would desire to draw particular attention to the sad state of matters which it discloses.

1. "As regards the disposal of nightsoil. The estimated annual production of excrement in a town of the population of Newcastle is about 4000 tons. It would seem that considerably more than half of that quantity is left to fester in the neighbourhood of the houses in which it is produced, only about 1700 tons being removed by the council in the course of a year. As this has been going on for years it is easy to imagine the present state of the soil of Newcastle which can best be described as a true hot-bed of disease, only requiring the introduction of the proper infective elements to give rise to the most frightful plagues.

"Moreover the quantity removed by the council (about 1700 tons a year) is deposited, of all places in the world, in a paddock closely adjoining the hospital and in the heart of the city.

2. "House refuse, etc.—The only recognised tip for house refuse and garbage is in a paddock close behind the hospital ; this institution is consequently infested by flies and subject to horrible effluvia. This most improper procedure is continued in defiance of the order of the late Colonial Secretary, who directed the council to cease from depositing garbage in this situation. But the council considered that order as *ultra vires*, and determined to show their independence by continuing a practice which every competent authority will acknowledge to be in the highest degree reprehensible.

"It appears also that in Newcastle it is the custom to deposit quantities of house refuse at the request of unscrupulous landlords on any vacant space of ground which it is proposed to convert into building sites ; and that the Mayor is prepared to defend this very improper and insanitary proceeding.

"Generally the scavenging of the town seems to be performed in a careless, perfunctory, and improper manner.

3. "From the position of Newcastle as a large seaport it is eminently exposed to the introduction of epidemic diseases such as cholera, yellow fever, or the like. Should any such disease take root in the town in its present filthy condition we may reasonably expect an outbreak of pestilence which would be fatal to the progress of Newcastle and highly injurious to the whole of Australia.

4. "I would draw the attention of the hon. Colonial Secretary to the gratifying fact that a Sanitary Association has been recently formed in Newcastle under the presidency of an eminent medical man, Dr. Cosby Morgan. Its members are drawn from all classes of society and include all the medical practitioners in the town.

"The best results may be hoped for from the action of this association in bringing moral pressure to bear on the negligent municipal council, and in gradually educating the public to a due sense of their danger.

5. "But as the influence of this association must necessarily be gradual in its action, and as the circumstances of the town are, in my opinion, attended with the most urgent danger, I would recommend that a copy of these papers be sent to the Municipal Council of Newcastle, and that they be called upon to abate the nuisances complained of within a period of four months, and to the satisfaction of this department. Should they neglect or decline to perform this duty I would respectfully recommend that the Governor be moved to exercise the powers entrusted to him by the 8th section of the Nuisances Prevention Act by taking such steps as may be necessary to carry out the Act in its entirety.

"I would also suggest that a copy of these papers be forwarded to the President of the Newcastle Sanitary Association.

"H. N. MACLAURIN,
"Medical Adviser.

"The Principal Under-Secretary—B.C."

[CONTRIBUTED.]

THE CARE AND TREATMENT OF THE INSANE.

(Continued from page 24.)

The close relation and interdependence that would exist between the hospital for new admissions, the asylum for long-term patients and the boarding-out system, would render it necessary that all should be situated near one another, in the same district or neighbourhood, for changes of residence should occupy as little time as possible on account of the risk to the patient's health. For purposes of supervision also, close proximity of the various parts of the system for the care and treatment of lunatics would be desirable. Conversion of the present asylums to serve in such a system would thus involve, (1) the addition of an hospital for all admissions and for the treatment of early and hopeful cases ; (2) the erection of workshops outside the asylum walls, and the cultivation of the asylum reserves ; and (3) the boarding-out of patients of all suitable kinds, in cottages on the asylum grounds, where they might reside while taking their part in the work of the shops, the garden, or the fields. Full use could thus be made of the most extensive reserves around or in the neighbourhood of the asylums, though the boarding-out system need not be confined to asylum lands, or even to their im-

mediate precincts—the asylums, however, forming the *foci* of the system recommended. Thus easily might the present asylums be made part of a system of attending to the needs of the insane, which more than any other has stood the test of time, and is yet advocated by many who do not think it right to reject the system because a few abuses may be found associated with it. The colony of Gheel could in this way be imitated in every asylum district, and while its faults need not be copied, the many qualities recommending it may always be improved upon. Increase of the area of reserved land in the neighbourhood of the asylums, with a view to cutting it up into small farms, would be another necessary step. These farms could be let by preference to attendants who might wish to retire from the more trying life in the asylums, and the working services of one or more lunatics be allowed in return for the necessary care required by those and by other insane persons boarded with them. In such colonies for the insane, the old asylum building could be relieved of more than the number overcrowding them, and that for many years to come.

The extension of the present asylums into colonies for the insane would not preclude the establishment of separate institutions for special classes of patients. Such might be built in association with the colonies of lunatics, but not necessarily so. Separate asylums for idiots and for habitual drunkards are a recognised necessity, and the existence of a class of patient common to benevolent and lunatic asylums, appears to suggest further disintegration of the present heterogeneous collection of cases all under the one haphazard system of care and treatment. The desirability, and, indeed, necessity for private asylums in a civilized community hardly admits of question. If there be exercised supervision such as that recommended in previous articles for the Government institutions, namely, by the Commissioner in Lunacy, Inspectors and Official Visitors, it will not be the fault of the system if abuses are not effectually prevented. If the proprietors of such private retreats prosper, it would be for the authorities to make sure that in no respect should the latter be allowed to degenerate in any particular below the standard of the state asylums. They could be established in asylum districts, so as to receive the same supervision as the public institutions. They might be more or less complete in themselves, or be auxiliary to the colonies of insane, making use of the boarding-out system in common with the latter.

At present, the only alternative lies between keeping the patient at home, subject to the pernicious influences that gave rise to his malady, and sending him off to a work-house-like asylum,

to herd with all sorts and conditions of lunatics, gathered in from all classes of society, there to be subjected to the same system of care and treatment served out to all alike, irrespective of their individual needs. Under such circumstances, on what rational grounds can any one maintain that private asylums should not form an important and essential part of any scheme for the care and treatment of the insane? Abolition of private institutions would virtually fix the standard of the public asylums at a comparatively low level, and while that standard would constantly tend to sink lower, there would be no incentive towards raising it till abuses had become sufficiently odious to set in motion the cumbrous and slow machinery of Royal Commissions and debates in Parliament, with imputations of mismanagement and clearing away of vested rights—and no better standard to be found without resorting to foreign systems of management. The rates charged for residence and treatment in private retreats would ~~enable~~ ^{enable} proprietors to supply the latest improvements with a promptitude that would be impossible in the case of the more unwieldy State system, and the officers as well as the proprietors, even though they were not allowed to retain the whole of the profits they made, would have a legitimate motive in keeping up a high standard of efficiency, which would be wanting in the case of government officials.

Before deciding whether a separate asylum for criminal lunatics ought to be established, it is necessary to take into consideration the various conditions and requirements of the inmates to be thus provided for, the institution being presumed to be established for them, and not that their treatment should be regulated in accordance with sentiment or other extraneous ideas. The term "criminal lunatic" obviously comprises a very varied class; indeed, their possible varieties are as numerous by virtue of their mental defects as those of the whole body of lunatics, while a further subdivision according to the nature and degree of the crimes laid to their charge, would seem to render any scheme of separate classification impracticable. The question would, undoubtedly, be most simply and at the same time most humanely solved by looking upon "criminal lunatics" as human beings whose insanity is a misfortune which calls for a charitable leniency, and demands that every effort should be made to restore them to such a state of mental health as would enable them to make profitable use of their faculties, as well as to benefit by such punishment as they deserve. The objection to the association of "criminal" lunatics with other insane persons is almost entirely sentimental, and could be guarded against without secluding them in a separate institution

by themselves. Even in a distinct asylum, sentiment could not well be denied a place, and it would have as much scope there for finding fault with the mode of association of the inmates, as it has at the present time with reference to the existing asylums.

In attempting to classify the so-called "criminal lunatics," other distinctions would have to be made than those according to the degree of criminality, and the degree or form of insanity. The nature of the connection between the insanity and the crime is of the first importance, and particularly so from the sentimental point of view, which is much modified by its consideration. We have (1) criminals whose lunacy was not the cause of their crime, but occurred subsequently to its committal, and in these the crime may or may not have any connection with the insanity. Some, again, (a) would retain their criminal instincts through it all, while others (b) would be rendered incapable of further crime by the disease affecting their minds. (2). There are others, classed as criminal lunatics, whose insanity has been the sole cause of their criminal acts or tendency; such would be objects of pity rather than of punishment, and their proper place would be in an hospital or asylum instead of a gaol. Their criminal acts were only symptoms of their mental disease, and while some may have been tried and sentenced as criminals, others may simply be dangerous lunatics in the ordinary sense. Many are no more responsible for their criminal acts than ordinary lunatics are for non-criminal symptoms. The medical aspect of crime is not always sufficiently taken into consideration in courts of law, and the connection between it and insanity is perhaps closer than it is often thought to be. It is evident that, of all the varieties specified, only those whose insanity has had nothing to do with their offences against the law, and does not diminish their capacity for further acts of the same nature, could reasonably be subjected to punishment, or even be denominated criminal. All others would, without question, have every claim to the most liberal treatment and supervision as lunatics. It would be interesting to know what proportion of the whole of those classed as "criminal lunatics" is formed by that sub-class in whom insanity is, so to speak, an accident. For such alone could sentiment reasonably demand a distinct and separate asylum; and after all the question of the dependence of the criminal impulse on the mental disease would in many cases remain unsettled. The majority of asylum inmates would probably never think of distinguishing between criminal and non-criminal amongst their companions; and, indeed, there is no reason why they should even suspect it. If correctly classified for purposes of treatment in the various parts of the asylums,

there would be no injustice done, and no one except a few of the officers need know anything of the patient's antecedents.

The medical treatment of insane criminals, whether in a special asylum or not, would be of diminished value and uncertain in its results, if the legal punishment were perforce carried out at the same time. The hard discipline of the gaol, instead of being salutary, is in some cases productive of insanity, and it would certainly interfere with the indulgent type of treatment now thought necessary for mental diseases. The humane method would be to give them the benefit of the alternative, and allow them all the treatment necessary for their disorder without stint, provided it is known to be necessary and reasonably hopeful for their improvement. Give the medical officers *carte blanche* for their treatment, at the same time that the eye of the law is kept on them, to see that their punishment is not abrogated unnecessarily, and, also, that their treatment has some reference to their possible relapse into crime in the future. On expiry of their sentence they might then be classified again among the general body of the insane, but not without precautionary measures against future possible outbreaks of their crime, or against an exacerbation of their insanity, for the two may be related or even more or less identical in origin.

The many varieties of criminal lunatics, insane criminals, dangerous or harmless in both categories, would require constant changes in their classification, according to changes in their mental condition or in their criminal status, so that if there were a separate asylum for all connected with crime, removal from thence to the places assigned them among the general body of lunatics would be both troublesome and detrimental to their mental health.

It appears, then, as if the disposal of so-called "criminal lunatics" would be met by appropriate classification in the various parts of the institutions for the treatment and care of the insane—such classification, namely, as is suited to the treatment of the mental states of the inmates. At the same time a lunacy ward might be provided in the penal department for such as would receive no benefit from residence in an asylum, if the corrective form of treatment were hopeful of good results. Punishment and medical treatment have this in common, that the object of each is correction of present and prevention of future deviations from the normal.

Classification of the inmates within each of the different forms of asylum is to be determined by consideration of the object aimed at in placing them there. In all but a few of the cases suitably detained in asylums for the insane, treatment with a view to cure or amelioration is by far

the most important object of their presence there. When so much in the treatment of lunatics depends on the surrounding conditions, it is apparent that the barrack system is the most unsuitable that could be devised, while the cottage system appears to offer the fullest scope for removing the patient from hurtful influences, and subjecting him to treatment appropriate to his individual needs. Hence we may assume the cottage as the type of asylum construction, let the variations from that type, for convenience sake, be what they may.

The method of aggregating similar cases in wards is well adapted to the routine treatment of large numbers *en masse*, but for all, except the chronic and demented, it is quite unsuitable and even pernicious, the presence of similar cases being detrimental to recovery. The continental system of classification in sections is of a degree more favourable than their aggregation in wards, as each section, while suited to a particular class, can still be so broken up and varied as to meet the requirements of smaller groups, or even of individual cases. Sections might thus be approximated to the cottage system; but as the patients require companionship, though not of those having the same form of disease, the presence of inmates subject to other forms of disorder would be less objectionable. To go further, the society of perfectly sane people would have a curative tendency instead of being detrimental, and thus we return to the boarding-out system as the most perfect means of combating mental disease. Classification according to types of disease in the wards of large buildings or in sections is thus unsuited to curable cases. For incurables it would prove economical and convenient for routine purposes, but of the two varieties, wards and sections, the latter in large asylums would be more comfortable for the inmates, and perhaps as economical as the former.

The hospital for recent cases of insanity would necessarily partake of the character of an ordinary hospital, in so far as the arrangements for thorough study of the cases were concerned, but at the same time the appliances would have to correspond to those of the asylums. A large proportion of the accommodation should consist of cottages, with liberal provision of land for purposes of recreation and outdoor work or exercise. But though such an hospital would bear some resemblance to an ordinary infirmary, the superintendent's duties would place him in a different position with reference to the general management from that held by the medical superintendent of the infirmary, lunatics demanding a wider range of appliances for their care and treatment. The present asylum superintendent,

in fact, must combine the functions of the lay superintendent or committee of management of the ordinary hospital, with those of the honorary physicians as well as the medical superintendent. Comparison of the duties of the head of an asylum with those of the ordinary hospital superintendent thus shows how onerous his position is, and indicates the amount of attention individual lunatics may be expected to receive after admission to asylums so ill fitted for systematic treatment.

The most powerful reason for the early transmission of recent cases to asylums is, that it is only by that means that treatment can be procured at a time when it is most likely to be of any avail as a curative agent. Viewed in this light, the early despatch of the patient to an asylum is of urgent importance, but in spite of its urgency there will always be obstacles to prompt action in this direction. The relatives and acquaintances of incipient lunatics cannot be expected to recognise insanity in its earliest stages as a disease, nor to be aware of the necessity for prompt treatment, either at home or after removal to an asylum. They rather set down the symptoms shown by their friend as variations in his ordinary temper, spirits or behaviour, or as part of his idiosyncrasy, and so far from looking upon them as signs of mental derangement they are apt to regard them from a personal point of view, according to the effects such peculiarities of conduct produce in their own minds, without a thought of their real nature. The friends may thus go on wondering, expostulating, or quarrelling with the incipient lunatic till the aberration, fed perhaps by opposition, advances from bad to worse, and something outrageous in his conduct enlightens them, or till cooler onlookers, who are free of personal bias, discover what to them was so obscure. Another cause of tardy recognition exists in the fact that in cases where there is hereditary predisposition to insanity, the family intelligence or power to take action may be deficient. The question here arises, who is to recognise the nature of symptoms of unsoundness of mind, or take action towards having the person placed on the way to suitable treatment? Obviously, medical practitioners are the proper judges of such symptoms, but as a rule they only observe them when consulted on the subject of derangement of the general bodily health associated with them. If, however, mental diseases were made a necessary part of medical study, the services of medical men would be more in request in such cases when the public came to recognise disorder of the mind as included within the scope of practical medicine.

(To be concluded in next issue.)

THE MONTH.

NEW SOUTH WALES.

AT the meeting of the Medical Section of the Royal Society of N. S. W., held on October 15, the following resolution was proposed and unanimously carried, "That the section has heard with deep regret of the death of Dr. Walter Fawkes Mackenzie, and that the section do now adjourn as a mark of the respect and esteem with which he was regarded." The meeting then adjourned until the evening of the 22nd October.

PROFESSOR LIVERSIDGE has been granted leave of absence during the year 1887 for the purpose of visiting Europe, chiefly in order to make himself more practically acquainted with the changes which have been taking place in the great European and American centres of scientific work and thought, and more especially the radical changes which are being made in the methods of teaching practical chemistry. Mr. Edwin Quayle, of Owen's College, Manchester, has been appointed to carry on the work of Professor Liversidge's chair during his absence.

DR. JAS. WILSON, a new arrival, has been appointed Demonstrator in Anatomy at the Sydney University, his duties to commence in March, 1887.

DR. J. F. ANDERSON, late of Urana, has succeeded to the practice of Dr. Agassiz, at Cootamundra, the centre of a large pastoral and agricultural district, 253 miles S. of Sydney.

MR. ERNEST GREGORY BLAXLAND, M.R.C.S. Eng., L.R.C.P. London, who has recently returned from his medical studies in England, has been appointed Assistant Medical Officer for the Coast Hospital, near Sydney.

DR. JOHN LE GAY BRERETON, M.D. St. And., L.R.C.S. Ed., L.S.A. Lond., 1851, died at his residence, Osgathorpe, Gladesville, near Sydney, on October 28, at the age of 59. He was a native of Bawtry, in Yorkshire, and was the son of a prominent physician in that town. He came direct to this colony in 1858, having been induced to do so by the late Mr. T. S. Mort, and he resided in or near the metropolis ever since. He secured a good practice here, and his genial disposition won for him the esteem of a very large number of persons, and secured for him many friends. A few years ago he retired from his profession and proceeded to his estate, "Osgathorpe," at Gladesville, where he devoted much of his time to literary pursuits, and also performed the duties of a justice of the peace.

DR. J. C. COX, of Sydney, has been elected Chief Medical Referee of the Australian Mutual Provident Society, vice Dr. W. F. Mackenzie, deceased. There were 28 applications for the office.

DR. M. EGAN, who since May, 1863, has held the offices of Police Surgeon and Superintendent of the Vaccine Institute, retired on the 1st of October on a well-earned pension. Dr. Egan, before entering the Colonial Civil Service, held office in this colony in the Imperial Service as Assistant Staff Surgeon to the Military Forces.

DR. R. L. FAITHFULL, of Phillip Street, Sydney, having succeeded to the practice of the late Dr. W. F. Mackenzie, has removed to 5, Lyons' Terrace, Hyde Park.

DR. JAMES E. JEFFERIS, son of the Rev. Dr. Jefferis, LL.D., has commenced practice at Newtown,

a suburb adjoining Sydney, in conjunction with Dr. J. Bruce, of Erskineville Road.

DR. GEO. MARSHALL, of Sydney, has been appointed consulting medical adviser to the Education Department in place of the late Dr. Mackenzie.

DR. K. I. O'DOHERTY, late of Brisbane, has commenced practice at 53 Castlereagh Street, Sydney, the late residence of Dr. W. Morris, who has left for Europe by the R.M.S. "Massilia." Dr. Morris has expressed his intention of returning to the colony in about fifteen months, when he will recommence practice in Sydney.

DR. L. D. PARBY, Medical Officer of the Hill End Hospital, recently delivered, in connection with the Hill End Boys' Friendly Union, a series of interesting lectures on "First help, or what to do before medical aid can be obtained," explaining to a most attentive audience the procedure in cases of apparent drowning, sunstroke, snake-bite, scalds, &c., ending with ambulance and stretcher drill.

DR. W. S. PARTRIDGE, formerly of Stroud, has commenced practice at Nymagee, the centre of a copper-mining district, 441 miles W. of Sydney.

We regret to learn that Dr. J. C. Sibley, the Assistant Health Officer for Port Jackson, is seriously indisposed, and in consequence is absent from his duties on sick leave. Dr. George Goode, recently of Camden, is acting as Assistant Health Officer during Dr. Sibley's illness.

DR. ALFRED STEVENS, late of Tauranga (N.Z.), has commenced practice at Hurstville, a growing suburb, 10 miles S. of Sydney.

DR. WM. E. STRONG, who for so many years has so ably managed the Liverpool Asylum, has succeeded Dr. Egan in his office under the style and title of "Govt. Medical Officer and Vaccinator for Sydney."

MISS DRIVER, certificated nurse, late of the Prince Alfred Hospital, is prepared to undertake the nursing of cases, either medical or surgical. References can be furnished on application to Miss Driver, care of Mrs. Hawkins, Railway Parade, Burwood, near Sydney.

We have been requested to call the attention of our readers to the handsome building now in course of construction at the corner of Hunter and Phillip Streets, Sydney, the first floor of which is being specially constructed in two or three suites for medical practitioners. If engaged before the building is too far advanced, the proprietor will be happy to adjust fittings, &c., to suit the tenant. Mr. Lewis, of 12 Pomeroy Chambers, Castlereagh Street, Sydney, will furnish further particulars on application.

NEW ZEALAND.

DR. E. C. FOOT, late of Alexandra South (Otago), has removed to Greymouth, the seaport of a gold and coal-mining district, 38 miles N. of Hokitika.

DR. W. W. LINNEY, a new arrival, has commenced practice at Hastings, the centre of a rich agricultural and pastoral district, 12 miles S. of Napier.

QUEENSLAND.

THE water supplied from Ennogera and Gold Creek reservoirs is now so bad that 18 medical practitioners have issued a joint protest stating that the water is quite unfit for use, either for washing or bathing or drinking, and that such a supply is fraught with great danger to the health of the community.

DR. AXEL. A. F. KORTÜM is to be recognized as Imperial Vice-Consul for Germany at Cooktown.

DR. W. M. FISHER, a new arrival, has commenced practice at Townsville.

DR. A. W. HAWTHORNE has settled at Winton, in a pastoral district, 1030 miles N.W. of Brisbane.

DR. F. PAOLI has recommenced practice at Charters Towers.

SOUTH AUSTRALIA.

AT a special meeting of the Senate of the University of Adelaide, held on Wednesday afternoon, October 20, a motion approving of the regulations for the degree of Bachelor of Medicine was carried after a short discussion.

DR. J. R. PALMER, late of Melbourne, has settled at Port Wakefield, on the shores of St. Vincent Gulf, 82 miles N. of Adelaide.

TASMANIA.

DR. C. H. ELLIOTT, late of Adelaide, and formerly of Fremantle (W.A.), has established a Health Resort at Evandale, a pleasant town on the South Esk river, 12 miles by rail from Launceston. Dr. Elliott, having a good large house, with over 20 rooms, now receives invalids or health seekers generally, at terms from two guineas upwards a week.

VICTORIA.

A SPECIAL and private meeting of the Central Board of Health was held on October 18, to consider the action of the Sydney Board of Health in quarantining the Messageries Maritimes a.s. "Oceanian" for more than 48 hours after she had been granted a clean bill of health by Dr. Browning and Dr. Shields on behalf of the health authorities of Melbourne. A letter was read from the Sydney Board of Health stating that additional quarantine had been ordered in this instance because there had been no independent disinfection of the ship, and the isolation of a patient on board who had suffered from small-pox during the voyage had been untrustworthy. It also appeared from the letter that the Sydney Board gave a new interpretation to the rules agreed upon at the Australasian Sanitary Conference, and which fixed the date at which a vessel was to be considered clean after contagious disease had occurred on board. The Board decided to confirm the action of Dr. Shields and Dr. Browning, and further resolved that, having regard to the interests of commerce, the new reading of the rules which had been adopted in Sydney could not be enforced. Hence the Chief Secretary will be advised by the Board that no order should be made on the subject of the action of the New South Wales authorities until the matter is dealt with by all the colonies in unison.

THE Council of Agricultural Education have instructed the officer in charge of the Dookie Model Farm to make experiments at Dookie with medicinal plants, particularly *peppermint, lavender and liquorice*. (The italics are ours.)

AN action was tried in the Supreme Court on October 22, before Mr. Justice A'Beckett, in which Dr. Thomas Rowan, of Melbourne, sued the executors of Miss Louise Upton, deceased, for £212 2s., due on an agreement made by Miss Upton to pay that sum for the performance of a surgical operation upon her. Miss Upton had been suffering from an abdominal tumour, and was attended by Dr. Carstairs, of Geelong. By the advice of Dr. Carstairs she consulted Dr. Rowan, and

Dr. Rowan advised that an operation should be performed. He told her that the operation was a serious one, and might possibly result fatally. She said she was willing to risk the operation. Dr. Rowan wrote to Dr. Carstairs, stating that he would take Miss Upton into his private hospital, and that his fee must be £210, and, if Miss Upton could not afford that amount, he should be glad to perform the operation at the Lying-in Hospital for nothing. Miss Upton came to Melbourne, and went to Dr. Rowan's private hospital, where he performed an operation on her, removing the tumour. He was assisted by Dr. J. W. D. Hooper, resident surgeon of the Lying-in Hospital, and by Dr. S. J. Burke, and Dr. Small, of Geelong. During the operation a bottle of ether burst, causing an explosion, but this did not affect the result of the operation. Miss Upton died three days after the operation was performed. Her executors thought the charge made by Dr. Rowan was too high, and refused to pay it. They paid £100 into Court for the operation, and £2 2s. for the previous consultation. Mr. Justice A'Beckett was of opinion that there was a contract made by Miss Upton to pay the sum sued for, and he directed the jury to give a verdict for that amount. The jury gave a verdict for the plaintiff for the sum claimed.

AN action was commenced in the Supreme Court on October 26, before Mr. Justice A'Beckett, in which Mr. W. T. M'Farland, landlord of the Palmerston Hotel, Carlton, sued Dr. James Marmaduke Rose, M.L.A., for damages for malpractice and neglect in attending plaintiff for a dislocated hip and fractured thigh. Plaintiff claimed £3000, and alleged that he had been crippled for life owing to defendant's negligence. The defence was that Dr. Rose had used the best professional skill and care, and that the permanent injury which the plaintiff was now suffering from was the result of his own violent and intemperate habits. The action was concluded on October 29, when the jury gave a verdict for plaintiff, damages, £600.

CASES of measles are reported from Box Creek, near Gunbower, in the Swan Hill shire.

AT the State school at Waterloo, near Beaufort, 162 children are absent on account of measles in the families to which they belong; the attendance has dwindled down to 30, and it is recommended that the school should be closed.

FOUR case of death from diphtheria are reported from Raglan, a small township 6 miles from Beaufort.

AT the South Melbourne Police Court, on October 9, a milk vendor was fined £15, with £3 3s. costs, in default one month's imprisonment. The evidence of Mr. F. Dunn, the municipal analyst, proved that the milk sold contained about 40 per cent. of water.

AT the Port Melbourne Police Court, on November 1, a dairyman was fined £20, with £3 3s. costs, for having sold milk which contained at least 12 per cent. of added water, as shown by the evidence of Mr. Dunn, the analyst to the borough.

DR. ALEX. S. AITCHISON, late Resident Surgeon of the Sick Children's Hospital, has commenced practice at Chester House, Merton-street, Albert Park, South Melbourne.

THE estate of Dr. Robert Peel, of Collins-street, Melbourne, has been compulsorily sequestrated in the Insolvency Court.

DR. W. P. MURPHY, late Assistant Medical Officer of the New Norfolk (Tas.) Asylum for the Insane, has commenced practice at Gre Gre, a township 164 miles N.W. of Melbourne.

DR. A. A. FLETCHER, late Resident Medical Officer at the Melbourne Hospital, has just returned from England, and commenced practice in conjunction with his father, Dr. E. Fletcher, at Holcombe House, Lygon-street, Carlton, a suburb adjoining Melbourne.

JOHN HENRY HILL LEWELLIN, M.R.C.S. Eng., 1842, J.P., died at his residence, Westbury-street, East St. Kilda, Melbourne, on October 12, in his 69th year.

DR. M. PERCEVAL, a recent arrival in the colony, has been elected Resident Surgeon of the Clunes District Hospital.

DR. J. J. PRENDERGAST, late of Guy's Hospital, London, has commenced practice at "Atherstone," Eville-place, Albert Park, South Melbourne.

MEDICAL APPOINTMENTS.

Amess, James, M.B. & Ch.B. Melb., to be Health Officer for shire of Yarrawonga, Vic., vice Dr. C. W. Rohner, resigned.

Beckett, Thomas George, L.R.C.P. & R.C.S. Ed., to be Health Officer for shire of Korong, North riding, Vic., vice Dr. H. C. Joe, resigned.

Connor, Samuel, M.D. Qu. Univ. Irel., to be Surgeon, with the relative rank of Captain, of the Victorian Mounted Rifles.

Cremomini, John, M.R.C.S. Eng., to be Resident Medical Superintendent of the Lunatic Asylum, N.Z., vice Dr. James Young, resigned.

Cumming, William, M.D. & Ch.M. Edin., to be Health Officer for shire of Lowan, W.R., Vic.

Degner, Charles Henry, M.D., to be Public Vaccinator at Wyche-proof, Vic., vice Dr. H. C. Gee, resigned.

Eisner, Frederick William, L.K.Q.C.P. Irel., F.R.C.S. Irel., to be a Surgeon in the Victorian Militia.

Foot, Edward Charles, M.B., L.R.C.S. Irel., to be an additional Public Vaccinator for the district of Greymouth, N.Z.

Grady, John Fitzgerald, M.D., to be Govt. Medical Officer and Vaccinator for the district of Sunny Corner, N.S.W.

Gregory, William, M.D. Aberd., F.R.C.S. Ed., to be Public Vaccinator at Kerang, Vic., vice George Wakefield, L.S.A., resigned.

Hawthorne, Alfred Wynter, M.D. & Ch.M. Roy. Univ. Irel., to be Government Medical Officer at Winton, Qu.

Iffa, Solomon, L.F.P.S. Glas., to be Public Vaccinator at Sunbury, Vic., vice Dr. G. H. Salter, resigned.

Leacock, Charles George, M.R.C.S.E., L.R.C.P. Lond., to be Govt. Medical Officer and Public Vaccinator for the district of Camden, N.S.W., vice Dr. G. Goode, resigned.

McCaw, Hugh, M.D. & Ch.M. Glas., to be Public Vaccinator for the district of West Taieri, N.Z.

Mackenzie, Murdoch, L.R.C.P. & R.C.S. Ed., L.F.P.S. Glas., to be Deputy Medical Superintendent of Hospitals for the Insane in Victoria, for six months, on probation.

MacLachlan, Hugh Kennedy, L.R.C.P. Edin., L.F.P.S. Glas., to be Public Vaccinator for the Duntroon district, N.Z.

Maclean, Hector Rath, M.B. & Ch.M. Edin., to be Health Officer for the Port of Williamstown, Vic., vice Dr. D. Maclean, resigned.

Montgomery, John Park, M.B. & Ch.B. Melb., to be Health Officer for shire of Narracan, Vic., vice Dr. H. O. Moore, resigned.

Murphy, William Patrick, M.B. & Ch.B. Melb., to be Public Vaccinator at Gre Gre, Vic.

Palmer, John Richard, L.K.Q.C.P. Irel., L.R.C.S. Irel., to be Public Vaccinator at Adelaide, S.A.

Reid, George More, M.D. Edin., M.R.C.S.E., L.R.C.P. Lond., to be Officer of Health for shire of Newstead, Vic., vice Dr. H. Smith, resigned.

Robertson, Robert, F.F.P.S. Glas., to be Public Vaccinator at Adelaide, S.A.

Taylor, David, M.B. & Ch.M. Aberd., to be Public Vaccinator at Omeo, Vic.

Terrey, Caleb, M.B. & Ch.M. Ed., to be Govt. Medical Officer and Public Vaccinator for Kiama, N.S.W.

Thomas, Walter Duncan, M.B. Lond., M.R.C.S.E., to be a Surgeon in the Queensland Defence Force.

Withers, Thomas John, M.D. & Ch.M. Qu. Univ. Irel., to be Public Vaccinator for the district of Rakau, N.Z.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Llewellyn, James Davies, L.R.C.P. Lond., 1886; L.S.A., Lond., 1882; M.R.C.S. Eng., 1882.

Guyonot, Paul Louis, Assistant Surgeon, French Navy.

Stevens, Alfred, M. & L.S.A. Lond., 1886; M.R.C.S. Eng., 1882.

Freeland, Andrew, M.D. & C.M. Glas., 1884.

Wood, William Atkinson, M.B. & Ch.B. Melb., 1885.

Clay, William Rudolph, L.R.C.P. Lond., 1886; M.R.C.S. Eng., 1886.

Hawkins, William Robert, M.D. & M.S. Royal Univ. Irel., 1886; L.Mid.K.Q.C.P. Irel., 1886.

Moir, William, M.B. M.S. Aberd., 1883.

NEW ZEALAND.

Davenport, Harold Devereux, L.R.C.S.I.

Linney, William Wycliffe, L.R.C.P. Lond., M.R.C.S. Eng.

QUEENSLAND.

Fisher, Walter Muirea.

Latrobe, Frederick Scott.

Hawthorne, Alfred Wynter, M.D. & Ch.M. Royal Univ. Irel., 1883; L.Mid. K.Q.C.P. Irel., 1883.

SOUTH AUSTRALIA.

Palmer, John Richard, L.K.Q.C.P. Irel., 1873; L., 1875; L. Mid., 1874; R.C.S. Irel.

TASMANIA.

Drought, Percy James, L. & L. Mid. R.C.S. Irel., 1883; L., 1885, L. Mid., 1884, K.Q.C.P. Irel.

Payne, John Woollard, L.S.A. Lond., 1879, M.R.C.S. Eng., 1882.

VICTORIA.

Wolrige, Herbert Ernest Rhodes, M.R.C.S. Eng., 1879; L. & L. Mid. R.C.P. Edin., 1880.

McCarthy, Henry, L.A.H. Dubl., 1884.

Hamilton, John Harry, L.R.C.P. Lond., 1882; L. & L. Mid. R.C.S. Edin., 1880.

Mackenzie, Murdoch, L. & L. Mid. R.C.P. & R.C.S. Edin., 1885; L.F.P.S. Glas., 1885.

Armstrong, George Alexander, L. & L. Mid. R.C.P. & R.C.S. Edin., 1886; L.F.P.S. Glas., 1886.

Robinson, Archibald Clarke, M.D. Q. Univ. Irel., 1881; L. & L. Mid. R.C.S. Edin., 1882.

Additional Qualification Registered:—
Duncan, Robert Byron, F.R.C.S. Edin., 1886.

MARRIAGE.

MITCHELL — SPILLER. — October 27, at Tubbo Station, by the Rev. S. J. Lowdell, James Mitchell, M.B., Ch.M., of Narrandera, to Belle, daughter of J. H. Spiller, Esq., Tubbo Station, Narrandera.

REPORTED MORTALITY FOR THE MONTH OF SEPTEMBER, 1886.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Measles.	Number of Deaths from								
						Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	125,000	327	174	68	...	...	4	7	7	4	4	15	11	9
Suburbs	175,000	801	282	182	...	4	7	8	4	3	29	15	16	16
NEW ZEALAND.														
Auckland	33,161	105	35	13	...	2	...	2	...	1	...	1	3	2
Christchurch	15,265	33	18	6	...	...	...	1	...	1	4	2	2	1
Dunedin	23,243	63	29	15	...	...	...	5	...	1	1	1	3	1
Wellington	25,945	87	47	25	3	...	...	...	...	1	2	1	3	7
QUEENSLAND.														
Brisbane	32,571	116	31	16	7	...	1	...	8	5	9	3	2	2
Suburbs	19,112	98	33	7	...	...	...	...	...	2	3	6	1	1
SOUTH AUSTRALIA.	816,660	953	258	81	...	1	7	4	6	6	23	27	8	8
Adelaide	58,000	111	52	13	...	...	...	...	4	2	3	6	1	1
TASMANIA.														
Hobart	29,506	107	46	19	...	...	...	3	1	...	4	2	6	3
Launceston	18,610	63	23	8	...	...	...	...	...	...	3	1	2	...
Hospitals, Asylums, Gaols, &c. .	1,318	...	25	...	...	...	...	...	...	...	...	...	...	...
Country Districts.	85,767	260	69	...	...	2	...	...	...	...	...	...	...	...
VICTORIA.														
Melbourne	69,774	161	77	179	2	2	11	14	7	6	66	39	31	40
Suburbs	275,606	1,001	452	...	...	...	...	...	...	...	...	...	...	...

METEOROLOGICAL OBSERVATIONS FOR SEPTEMBER, 1886.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.			Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Inches		Depth.	Days.			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	82·5	61·	40·1	29·909	...	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	128	62·	53·1	41·5	...	3·050	19	74	...	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	...	92·	66·5	44·	30·121	5·43	18	77	S.W.	...	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	131	69·2	48·0	30·7	...	2·094	15	73	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	123	70·	47·4	32·	...	1·858	16	73	...	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	...	...	...	...	...	...	...	...	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	...	...	...	...	...	...	...	...	...	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	...	78·9	55·5	36·6	29·961	1·43	10	...	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.....	...	75·4	58·9	44·7	30·108	0·77	7	63	W.	...	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	125	62·8	49·9	34·	...	3·573	15	78	...	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

UNUSUAL SITE FOR HYDATID CYST —AN ADDITION TO THE RECOGNIZED VARIETIES OF INTRASCROTAL DISEASE.

READ BEFORE THE N. S. WALES BRANCH, B.M.A.
By PHILIP E. MUSKETT, HONORARY SURGEON
TO THE SYDNEY HOSPITAL.

It has probably fallen to the lot of most surgeons in the practice of their profession to have met with hydatid cysts in different regions of the body, and yet so far as my recollection serves me no case of intrascrotal hydatid has been recorded. This is the apology I have to offer in introducing the subject to your notice, and if I be in error with regard to a prior record, still I trust there will be found sufficient points of interest in the present case to render its narration not altogether uninteresting.

The question as to the likelihood of any tumour or swelling being hydatid should, in Australia at least, always be present in the surgeon's mind, and in the differential diagnosis of such cases due consideration must be given to the query, "Can it be hydatid?" Numerically (I speak from a town point of view), the disease will inevitably increase, for new country is being continually opened up by railway extension, and patients are thereby enabled to have greater facilities for consultation and treatment. Its recognition, therefore, will be rendered easier by the fact that its presence is not altogether unexpected, and the surgeon consequently will be less likely to fall into error, as the maxim "forewarned—forearmed," will apply to matters surgical as to most other things. In my own case, however, I must confess that till the cyst itself escaped from the aperture left by the trocar and canula, and that ten days afterwards, the true nature of the disease was not recognised, as will be detailed subsequently.

As to unique situations for hydatid disease in my own experience, I have found after death, in Douglas' pouch, a cyst the size of an orange, in a young girl who died of cardiac trouble; had opportunity permitted an examination during life it would doubtless have given rise to some difficulty in diagnosis. I have also been present at an autopsy when a cyst was met with in the pericardial sac. While House Surgeon at the Sydney Hospital I saw a cyst the size of a hen's egg, situated over the left deltoid muscle, which was taken to be an ordinary fatty tumour, till it was exposed by the scalpel. A few weeks ago a

young infant at the breast, sent in by Dr. M. H. Long, of Redfern, and operated upon by Dr. Harman Tarrant at the same hospital, was found to have several distinct hydatid cysts, enclosing daughter and granddaughter cysts, in the left axillary region, dipping and burrowing deeply down behind the scapula.

The diagnosis of intrascrotal tumours has always been beset with difficulty, and although no mention is made by the accepted English authorities as to the possibility of scrotal hydatid disease, yet with us in the Southern world, it must have distinct claims for careful consideration. Bryant, who has written fully on scrotal and testicular disease, makes no mention of hydatid; neither does Erichsen, though the latter records instances of it in the breast, in the neck, and three interesting cases occurring in muscle—one in the deltoid, one at the outer edge of the latissimus dorsi, and one in the biceps. In the monograph on diseases of the male organs of generation—in Holmes' System of Surgery, by G. M. Humphrey (re-written by W. H. A. Jacobson, of Guy's Hospital)—there is no reference to the subject *sub judice*, and the same remark applies to the work on Surgery: its Principles and Practice, by T. Holmes. Moreover, in Heath's Dictionary of Practical Surgery (W. H. A. Jacobson), in the article on the Diagnosis of Scrotal Swellings, does not allude to it; nor does Pearce Gould in his chapters on Diseases of the Testes, in the same work. Finally, in Neale's Medical Digest (last edition) there is no recorded case of intrascrotal hydatid.

As the case I have to record is somewhat interesting, I have endeavoured to give a full history. The patient, A. T., *ætat* 25, a native of Lancashire, was brought out to Brisbane by his parents in 1864, when he was three years of age. In 1874, he settled down at Gympie (Queensland), a gold-mining township, situated in a sheep district, where he was on the staff of the "Gympie Times," and, subsequently, on that of the "Gympie Miner." He describes the Gympie water as being very bad, and obtained from water-holes sunk in the ground. In 1878, he first noticed a swelling in the right scrotal region, which began at the lower part, and enlarged from below upwards. He took no notice of it for some considerable time, and was in the Temora rush in 1880, at which latter place he remained for 14 months, returning to Gympie in 1882. The swelling at the beginning of 1884 was nearly the size of "two shut fists," and immediately prior to this had enlarged very rapidly. It caused such dragging pain, from its weight, that he at last

sought advice, and consulted the late Dr. Macartney, of Townsville (Queensland), who tapped him and drew off nearly half-a-pint of "dirty-looking fluid." After this tapping it began to swell again, and soon reached its former size. Eight months afterwards he consulted Dr. Macdonald, of Rockhampton (Queensland), who re-tapped him, withdrawing not so much fluid as on the first occasion, about quarter-pint, which was much clearer than in the former instance. The latter surgeon then injected iodine into the sac, which did not give rise to much constitutional disturbance, but in three or four weeks' time it began to swell, and rapidly attained its old dimensions.

He subsequently found his way to the Sydney Hospital, and was admitted July 16, 1886. There was an intrascrotal tumour about the size of a large emu egg on the right side. It was smooth in outline, and in its general contour nearly oval. The tumour was tense and dull on percussion, but gave to the fingers on palpation the sensation of fluid within. There was no impulse on coughing, and it was irreducible. The position of the testicle, at its posterior part, was made out by the presence of testicular sensation. The cord could not be clearly defined at the upper portion of the swelling. Light was transmitted by the ordinary manner of procedure, and finally, as was mentioned previously, the history had been that of an eight years' growth, painless, except from its mere weight.

The House Surgeon (Dr. Westrum), on July 17th, the day after admission, tapped him with a fine exploring trocar and canula, and evacuated about one ounce of "serous looking fluid" of "pale yellowish tinge." A few days afterwards, his temperature rose repeatedly every evening two or three degrees above the normal, being attended with much heat and swelling about the tumour. I now determined (July 30th) to empty its contents, and for this purpose used a full sized trocar and canula, giving exit to about six ounces of purulent looking fluid. After this a good deal of pus daily drained away, and feeling satisfied that there was something demanding freer outlet, I proposed (August 10th) to open up the scrotum antiseptically on the following morning, insert a full-sized drainage tube, and then stitch the cut edges of the tunica vaginalis and integument together. In the afternoon of the same day however, an hydatid sac partly forced its way, and was partly extracted, through the opening left from the tapping 10 days previously. It presented the usual and unmistakable characters of an hydatid sac, being greyish in colour, translucent and elastic, and in its collapsed condition was of such a size as would about fill an egg cup.

From this time the swelling gradually subsided, the sinus ceased to discharge, the scrotum returned to its normal condition, and the patient was subsequently discharged cured.

It may not be out of place to mention here that I have seen the spontaneous expulsion of an hydatid sac on two other occasions, both in cases of abdominal hydatid which had been tapped some time previously. In the latter of these, in which, I imagine, the expulsion was effected by a process of inversion, I had established adhesions between the parietal and visceral layers of the peritoneum prior to tapping.

LATERAL LITHOTOMY, FOLLOWED BY SUPRA-PUBIC LITHOTOMY—RECOVERY.

By Wm. GARDNER, M.D., C.M., GLAS., SURGEON TO THE ADELAIDE HOSPITAL.

THOS. E—, æt. 36, married, consulted me first on the 19th July, 1886. Complains that he has had burning pain on passing water for the last twelve months, and on several occasions has passed blood in the urine. Previous health good, and has not suffered from any form of venereal disease. He seemed to have such a dread of pain, and was altogether so nervous, that I suggested the administration of ether whilst I examined the bladder. After taking a few whiffs however, he became so very excited that I stopped the administration, and quietly passed in the sound and immediately struck a stone. I had no opportunity of measuring it, and so I sent him down to the Adelaide Hospital, determined to perform lateral lithotomy in preference to lithotrity, as the size and character of the stone were unknown.

At 3 p.m., on the 22nd July, I performed the lateral operation, with McLeod's modification of Buchanan's Rectangular Staff, which I had not previously used. The Staff was introduced at an obtuse angle easily, and this was afterwards converted into a right angle by means of the left forefinger in the rectum. It was then fixed at that angle by means of the adjusting screw at the top of the handle. The bladder was entered at the first thrust of the knife, and the external wound was enlarged to the required extent as the knife was withdrawn. The finger immediately touched the stone, which was recognised to be of great size. Forceps were then introduced and

the stone grasped, but from the great width between the handles it soon became evident that the stone was of unusual size, and that it could not probably be removed with safety through the perineum. A supra-pubic opening was at once decided upon, and my assistant, Dr. Giles, filled up with water a Barnes' bag, which had been introduced into the rectum; it held about 8 oz. An incision was then made about 3 ins. long over the pubic bone, and with the help of a steel director I separated the tissues till the bladder appeared in view, but at a considerable depth in the wound. It could be felt collapsed and closely applied to a large mass inside of it. A short beaked sound was then passed in through the perineal wound, and on the turned up beak the bladder was incised, and the sides grasped with forceps. With the finger a large stone was then felt, and the forceps were applied, but slipped. A large-sized scoop was then passed into the bladder and under the stone. With this it was lifted up, and the bladder wound enlarged upwards until it could be safely delivered. The peritoneum could be seen bulging in the wound about $1\frac{1}{2}$ inches above the pubic bone, and was carefully protected from injury. At the suggestion of Professor Watson, who came into the theatre just as I was delivering the stone, I sewed the peritoneal surfaces of the bladder-wound together with carbolized silk for $2\frac{1}{2}$ inches, leaving just room in the lower part to insert a large drainage-tube. Another similar drainage-tube was placed in the bladder through the perineal wound. Throughout the operation the hemorrhage was slight. The edges of the superficial part of the abdominal wound were then accurately brought together with carbolized silk, and well dusted with iodoform. Gauze pads filled with salicylic wool, freely sprinkled with iodoform, were then lightly bandaged over the abdominal wound.

The calculus weighed 6 ozs. and 20 grs., and was covered all over with short spines. It is a large specimen of a mulberry or oxalate of lime stone.

I cannot conclude the account of this operation without drawing your attention to the ease and rapidity with which the bladder can be entered on the rectangular staff.

This case appeared to me to be worth reporting, as it is the first recorded instance of supra-pubic lithotomy in South Australia, and the stone is larger than any oxalate of lime of which there is any record in the authorities to which I have access.

My best thanks are due to the assistant surgeons, Drs. Giles and Jay, and my house surgeon, Dr. Aitken, who were present and rendered me valuable assistance.

CASE OF HYSTERICAL PARAPLEGIA.

By W. B. KESTEVEN, M.D.,
OF ENFIELD, MIDDLESEX, ENGLAND.

READING in the August number of the *A. M. Gazette* an extremely interesting narrative copied by Mr. Walter Dunn from the notes of his father, I am reminded of a somewhat parallel case that occurred in my own practice some years ago, and which I would offer to your notice, if you think it worth insertion in the *A. M. G.*

Some thirty years ago, as I was attending several cases of diarrhoea in a family, the mother of my patients remarked, "We have a sad case upstairs. My sister has lost the use of her lower limbs, and has been bed-ridden for two years. It is the more sad that she is a young woman, and in the enjoyment, otherwise, of good health." I was told that she had had the opinion of distinguished physicians in several of the larger towns and cities in the north of England, and had now come up to London for "further advice." An inkling of the possibly hysterical nature of the case passed through my mind, and I asked to be allowed to see the case. On being shown into her room, I found a remarkably healthy, fine young woman in bed, who declared herself helpless. After a little preliminary conversation, I put her off her guard by suddenly saying, "Will you let me look at your feet?" With her permission I quickly turned up the bedclothes from the foot of the bed. I then took hold of the great toe, and abruptly said, "Now bend this upwards," which she did. After drawing her attention to other subjects for a short time, I took hold of the foot, and in an authoritative tone ordered her to bend the ankle joint—a movement followed. I then told the "paralytic" that I could cure her, and would do so if she would give me her concurrence and help, and further promise to do what I told her, and take what medicine I might prescribe, however vile it might taste. The mixture I ordered her contained assafoetida, cubeb, and valerian. I paid her two or three more visits, manipulating the joints each time, until very shortly she rose from her bed, and in about a couple of months she was able to walk about like anybody else, with sound limbs.

So far, Mr. Dunn's case and mine run in parallel lines, but at this point the lines utterly and widely diverge. My patient returned into the country, and I have not since heard of her. As I was then a practitioner of several years' standing, the result was not so important to me professionally as it was satisfactory from a purely medical point of view.

THE MEDICAL PROFESSION AND CULTURE.

READ BEFORE THE

SYDNEY UNIVERSITY MEDICAL SOCIETY,
BY THE REV. J. KINROSS, B.A., D.D., PRINCIPAL
OF ST. ANDREW'S COLLEGE, SYDNEY.

As the Medical Society has done me the honour of asking me to address a few words to you on the present occasion, it would be unbecoming on my part to select a topic, the treatment of which would require a knowledge of the principles and practice of medicine. To the possession of such knowledge I should not presume to make the slightest claim. We all know that each man has a brain and spinal cord—the source, as you tell us, of nervous irritation—and that we possess digestive organs which are not always up to the mark, chiefly because, like most medical men and others who are not medical, they are often overworked. As this is about the extent of my knowledge, I come before you, therefore, as an outsider, possessing none of your secrets, but still, yielding to none in hearty appreciation of the noble aims of your profession. I have every reason, from my own experience, to speak well of the members of your body, and it is my decided conviction that there is no class of men who devote themselves to the service of humanity with greater zeal, and who, in deserving cases, render their services to the destitute without hope of reward.

Entertaining such views, I cannot but feel a lively interest respecting the relation in which this same profession stands to culture. On this, as on most other questions, a wise man will endeavour to combine conservatism and genuine progress. The medical has always been regarded as one of the three learned professions. This may be said to be one of your traditions. You have always been associated with the highest educational institutions, both in Europe and America. In every university fully equipped there has been a faculty of Medicine, subsisting side by side with the faculties of Law and Divinity. In connecting yourselves with our own University, so as to become an integral part of it, you are only following the traditions of all other countries where the healing art has been pursued. I venture to affirm, and I feel certain that you will agree with me, that this is a tradition which ought to be faithfully conserved. The efficiency of the medical profession in this land will demand that this close connection should always continue.

The more we consider the nature of medical study, the stronger our conviction will be that the custom of regarding the profession as belonging to the learned class is founded upon reason.

The facts with which you have to deal, and the principles which you have to apply, require a cultured intelligence to grasp them. Both in surgery and medicine something more than manual dexterity is necessary. Thorough familiarity with the nature and position of every part of the human body involves of itself no small amount of toil, even so far as the dead subject is concerned; but when you take the phenomena of life into account, as they present themselves, both in health and disease, the difficulty of grasping the facts of the case is very much increased. This is by no means all that has to be known, or with which the medical practitioner has to be thoroughly familiar, but he must know the relation in which the human subject stands to the world around. The kind of food that is most suitable, the influence of particular drugs upon the system, the effect of climate upon different constitutions and different diseases, are subjects that must be thought about, duly pondered, and the best conclusions arrived at. You will observe that I am putting these matters before you in a non-professional manner, and as an outsider, like myself, will most probably regard them. Accordingly we can come to no other conclusion than this, that that body of men who devote themselves to the study and practice of medicine ought to be possessed of superior intelligence, to have their powers of observation and their reasoning faculties well cultured, inasmuch as they have to deal with a vast variety of objects, each possessed of different characters. The hand, the ear, and the eye must all be well trained; but the discipline of the mind—the cultivation of reason—is quite as necessary as these. It so happens, however, that this necessity of mental cultivation is not so obvious as the other, and, consequently, it is often affirmed by superficial observers that the time spent in what may be called "Liberal"—in contradistinction to "Professional"—studies, is almost entirely wasted. There could not be a greater mistake, although there is a very strong tendency amongst professional men, as well as others, to fall into it. The same law holds good with regard to the cultivation of the mind as to the training of the body. Exercise in both is the one essential of growth and advancement, and variety of exercise is necessary to each. We should all cling as long as we can to freedom of movement and variety of action, for we are soon enough compelled to walk in the same old groove. This is the principle on which all systems of education worthy of the name are founded—to exercise our powers on *other* subjects or objects before we come to those which are to form the work of our life. When this is done, we are in a far better position to apply ourselves to the latter, which will then not so readily exer-

cise that narrowing and perverting influence upon our mental constitution and habits which otherwise they would all but inevitably do.

In the medical curriculum there are taught several subjects which are necessary only to a very limited extent to the practitioner, such as botany, zoology, and chemistry. If, in arranging the subjects of study, you are to have regard exclusively to practical utility, a very small modicum of these branches of knowledge would be required. It is well, however, for the interests of culture that the system of medical education in this colony does not rest upon such a principle. If such subjects as I have mentioned are not indispensable for the practitioner, they are assuredly conducive to the cultivation of the man. Train the *man* first, and then you can make him an accomplished physician. When one has acquired habits of careful and accurate observation, of patient investigation, of forming clear and distinct ideas on the matter in hand, and of weighing every fact presented to him in the impartial scales of reason, then he will bring his powers to bear with effect upon any subject connected with any profession. It is the want of this which is felt in all professions and callings; and the possession of this is the highest security for permanent success in them all. When culture has this place of honour assigned to it, then medicine will be treated scientifically, not as a mere profession, and still less as a trade. Both Law and Theology are just as liable to abuse in the latter respects. What may be called the liberal and professional, the rational and empirical methods, have been pursued in all the three. When culture, then, receives its due place, we should expect a scientific study of all matters strictly medical, and this will prove of immense service to the community at large as well as to the members of the faculty themselves. But should we not expect that professional men in general, and medical men in particular, should not confine their attention exclusively to their own subjects, but should make frequent incursions into the pleasant fields of literature? The exclusive study of any branch, however important and interesting in itself, becomes monotonous; and if it is not felt by the student himself to be of this character, other people will soon see that such an exclusive pursuit of one species of knowledge or of one mode of life is making him lop-sided. In my humble opinion all of us who are professional men have to watch carefully against such a tendency. When the lawyer is surrounded by clients, briefs, wills, &c., and thinks, talks, and reads of nothing else; when the preacher is engaged exclusively with sermon-making, household visitation, and church meetings, while his reading is limited

to these; when the medical man is engrossed with patients, fractures, and splints, with tonics and liniments, whilst his thinking and reading never extend beyond these—in all such instances one can easily perceive that this exclusiveness exercises a perverting influence upon the mind, keeps us in ignorance of what is going on around us, and prevents us from sympathising with our fellow men and from taking a hearty interest in the progress of humanity. In giving advice to patients you tell them that it is not good to remain always within doors in their place of business, whether that be behind the counter, in the clerk's office, in the study, or laboratory, but that they ought to go out to the open air as frequently as possible, exercise their limbs by climbing hills or travelling in the bush. Everybody knows that this is most excellent advice, and if complied with will result in lasting benefit to those for whom it is given, but it must be admitted that it is often, or perhaps generally, difficult to take; occupation, business, want of means, &c., keep men and women to one place, and prevent them from enjoying that amount of the pure air of heaven which the claims of their bodily constitution demand. Accordingly the professional man raises the same objection to a course of general reading. Where is he to get time? The sick room, the hospital, consultations, and so on, absorb all his hours. By day and by night he is at the call of every person who chooses to ask for his advice and help. Difficult and intricate cases are constantly arising which cause him great anxiety, and which, along with the visits which must be punctually paid, render it almost impossible for him to extend his reading beyond the *Lancet* and the newspaper. Every professional man has the same story to tell. The barrister, the minister of religion, the merchant, and the working man, have all got the same excuse to plead—want of time for reading and study beyond the just demands of the situation which they occupy. There can be no doubt that there is great force in the plea.

But are the difficulties in the way of culture to the medical man insuperable? Doubtless they are very serious, and require great care to be exercised as to the distribution of time and the arrangement of work, but with such care they may, I think, be overcome. The best proof of this is the fact that many physicians, having a large practice, have become distinguished literary men. It would be out of the question to mention many names of those belonging to your profession who have distinguished themselves in the literary world. The list, from the time of Sir Thomas Browne, the quaint author of the *Religio Medici*, who died at Norwich in 1682, to Dr. John Brown, the author of *Hora Subsecivae*, who died in Edinburgh a short time ago, would contain

many distinguished names. I will mention only two or three that occur to me while writing ; and the facts I can only give from memory. Dr. Mason Good translated into verse the Latin poet Lucretius ; and it is said that a considerable part of the translation was made during the time he was passing from the house of one patient to another. "Delta" was a distinguished contributor to *Blackwood's Magazine* for some years (he wrote some good poetry also), and was the author of that inimitable Scotch story, "The Life of Mansie Waugh, tailor at Dalkeith." "Delta" was a physician, living not far from Edinburgh, and his name was Dr. Moir. Those of you who have often to return home, tired and weary, after a hard day's work, could not obtain a better tonic than a perusal of "Mansie Waugh," whose author was a member of your own profession. The late Dr. Abercrombie, of Edinburgh, was first physician to the Queen in Scotland, and occupied the foremost place in his profession in that country. Dr. John Brown says of him, that he never knew him to be five minutes late in keeping any appointment, and yet, if Dr. Brown happened to meet him accidentally when a serious case required additional advice, he was always ready to go with him. Yet numerous as his engagements must have been, owing to his high reputation, he found time to publish, besides some works on his own special subject, treatises on the Intellectual and Moral powers of man, which have had an immense circulation, and which, at the time they were given to the world, were considered a valuable contribution to these important branches of human knowledge.

It is not to be expected, indeed it would be very undesirable, that every medical student should select some subject outside of his own particular walk, with a view to write a treatise upon it. The world has already been sufficiently flooded with works written by persons who had but a superficial knowledge of the topics handled in them. But although only a very few authors can be found in any profession, even in their own department, yet it is not unreasonable to expect that all our barristers and solicitors, our surgeons and physicians, our preachers and ministers, should be reading men, and that this reading should extend beyond the narrow limits of their special calling. No one need be at a loss for a branch of knowledge which may prove not only interesting but instructive and stimulating. The page of history is open to the inspection of every one of us, and is presented in a vast variety of lights in most of the languages of Europe. In the brilliant works of Gibbon and Macaulay, of Froude and Freeman, of Green and Motley, we can be introduced to the great lights of past generations, and see how men lived and toiled,

what sorrows they endured, and what enjoyments they experienced. Through the perusal of such works we are lifted above the concerns of the passing hour, and are enabled to mark the different steps in the onward progress of the race. We can go to the marvellous creations of genius exhibited in the classical poems which the ages that are past, as well as the present, have produced. We can follow the traveller in all his wanderings, even from the North Pole to the heart of Africa. To a man who has been compelled to read constantly about bones, and veins, and arteries ; about fractures, fevers, and pneumonia, such studies will produce feelings something like those which he should experience in escaping from the hospital or consulting-room into the open air or green fields. The more frequent our visits to these green pastures, and the more systematic, the better will it be for us as men, and the better, I venture to affirm, for those who are depending upon our professional skill and attention.

It is sometimes objected that those who give attention to literature are very apt to neglect their professional duties, and that the time spent in the former is so much deducted from the latter. That this is not necessarily so the former examples of cultured doctors which I adduced are sufficient to prove. Several of these mentioned occupied a high, some, even, the highest place of honour in the profession. Dr. Gregory, (whose name at least is familiar to those who are compelled to swallow unpalatable mixtures,) had a high reputation in his day, and is the author of a medical work written in Latin, "Conspectus Medicinae Theoreticae," and another entitled "Philosophical and Literary Essays." Every time you prescribe a Gregory's powder, the very name you write is a standing testimony to the fact that there is no antagonism between medicine and culture, but that they may be most harmoniously combined. One caution as to what might be inferred from this. As a matter of fact, some medical men, clergymen, lawyers, &c., have engaged in literature and politics, and neglected their practical duties. Of course, neglect of duty in any case is not to be tolerated. If a man is engaged in writing an article for a Review when he ought to be in the consulting-room or the study, and in reading poems, novels, or history, and neglects his professional studies, such a man does not succeed, and what is more, he does not deserve to succeed. Thorough knowledge of the subject he professes, requisite skill in applying that knowledge to individual cases, and a faithful and punctual fulfilment of all engagements, are, in the opinion of the public, and in the feeling of every conscientious man, imperatively required, and no literary skill or advanced culture can atone for the want of them.

Before I conclude allow me to express to you my hearty congratulations on the institution of this society, and my earnest desire for the prosperity of the medical school. I trust that students throughout the length and breadth of the land will flock to your class-rooms, and that our *Alma Mater* will send forth numbers of men thoroughly acquainted with all the branches of the profession, combining with this a broad and generous culture. They will thus feel that we are all parts of a great whole, that each profession and class are linked to each other, and have mutual duties to discharge. When we all feel that the claim of humanity is superior to class, and the love of God to our own interest, the future material, moral, and spiritual prosperity of the colony will be secured.

THIRTY YEARS LAMENESS AND IMPAIRED HEALTH PERFECTLY RECOVERED FROM, AFTER THE REMOVAL OF A LARGE CENTRAL NECROSIS FROM THE OS CALCIS.

By ROBT. DENHAM PINNOCK, M.B., C.M.,
GLASG.; OF BALLARAT, VICTORIA.

THE patient, W. E., was 46 years old when operated upon, married, wood merchant. Father died of dysentery and liver disease, æt. 46. Mother still living and in good health, æt. 70. A brother died of miners' asthma, æt. 49; another of acute rheumatism, æt. 26. One brother and two sisters living and in good health. Has had no disease himself except the one now narrated.

The heel first became painful and swollen and broke out at one place on the outside of the heel bone, when 15 years old, in Cornwall. He attributed it to wearing a tight boot. Matter and gritty bone used to escape from the opening, which continued to discharge for 9 years. Though lame all the time, he was still able to do light work. After discharging for 9 years, the opening healed up and did not break out again for 3 years, although the heel was swollen, and painful if he used it. During the voyage to Australia, in 1858, a thin flat piece of bone worked out at the point of the heel. (The only other occasion on which he recollects any bone coming away was 2

months before operation, when two pieces of the size of a sixpence worked out.) Three or four fresh openings now appeared round the heel, and later on others. These have always been discharging up to date of operation, and although he has always been trying to work, he has frequently been laid up for two or three months at a time. When I first saw him, some weeks before operating, the affected heel was greatly enlarged, edematous, red, and glazed, and extremely painful on any attempt to move the foot at the ankle joint or rest any weight upon it. There were three sinuses on the outside, equidistant from each other and parallel with the sole, the most anterior being just over the anterior process of the bone. One sinus just to the inside of the attachment of the tendo Achilles, and three sinuses in a line extending obliquely forward and downward from a point immediately below the attachment of the posterior calcaneo astragaloïd ligament to the inner margin of the sole. These were all discharging freely, and, on passing a probe, dead bone could be felt in the cavity of the enlarged calcaneum. I therefore performed Ollier's operation—as described in the standard works—hooking aside the tendo Achilles and peroneal tendons, and saving the periosteum. There was a mere shell of bone beneath, most of which was scraped away as it was diseased, and in the cavity, surrounded by pus and granulations, was a honeycombed, excavated, craggy, discoloured mass of dead bone, 1 inch 10 lines at greatest length, and $\frac{1}{4}$ inch at greatest breadth, a rough sketch of which is appended. This was attached at two points only to the periosteum, and was therefore easily lifted out, when the cavity was swabbed out with zinci chloride solution (grs. xx. to 3j.) and filled with oiled lint. The foot being lightly dressed with antiseptic gauze and laid on a soft pillow. The loss of blood was but slight, as Esmarch's elastic bandage had been previously applied.

In three months the incisions and sinuses were healed, but there was impairment of sensation on the dorsum of the foot. In six months the heel was reduced to its normal dimensions, sensation on dorsum was perfect, the foot was freely movable at the ankle, and he could bear all his weight on the toes, neither of which had been possible for 30 years. He has been able to do hard work from six months after the operation, and is 12 stone in weight, whilst prior to it he was never more than 10 stone 7 lbs. It is now two years and four months since the necrosed bone was removed, and as he is in excellent health, doing hard work, and has perfect use of the foot, the result of the operation may be fairly considered successful.

CASE OF MULTIPLE HYDATIDS OF ABDOMEN.

By T. CARSON FISHER, M.D., M.CH., RESIDENT MEDICAL OFFICER, SYDNEY HOSPITAL.

J. R., aet. 38, admitted into hospital on Sept. 29 for an abdominal tumour. He stated that he had always been fairly healthy. He had dysentery about ten years ago. Four years ago he was in this hospital for "enlarged prostate." His urine has never been bloody or thick. During last two months has had pain in left lumbar and iliac regions; this was severe at first, but has gradually diminished. For the last six weeks he has felt a "hardness" or lump there. He has recently lost one stone in weight, and has had occasional nausea and vomiting. [He is a native of Ireland, but has lived in N. S. Wales for last twenty years.]

On admission, he is a stout, florid man, in apparent good health.

In left hypochondrium, and extending nearly to crest of ilium, is a rather hard, circumscribed tumour; its posterior edge extends along back about four inches from spine. It is movable on deep inspiration, painless on manipulation, and fluctuation can be detected.

The urine was examined on several occasions, and was invariably clear, watery; sp. gravity, 1008 to 1004.

Oct. 7.—A fine aspirator needle was put into tumour, and a little milky, colourless fluid drawn off. Microscopically it contained oil globules, a few cholesterolin crystals, and granular debris.

Nov. 5.—Tumour punctured again. Fluid contained chlorides, no albumen. Microscopically as before; but a small piece of laminated layer of hydatid cyst was found. Four hair-lip pins were inserted by Dr. Tarrant in abdominal wall, midway between last rib and iliac crest, in order to produce adhesions.

Nov. 12.—An incision was made by Dr. Tarrant into the tumour, in the area enclosed by the hair-lip pins. Several small hydatid cysts and a little pus came away. A drainage-tube was inserted in the opening.

Nov. 13.—Symptoms of peritonitis set in, and he died at 7 p.m. on Nov. 14.

Autopsy 16 hours after death.

Abdomen.—Peritoneum coated with recent lymph. Hydatid fluid and numerous small cysts were found free in peritoneal cavity. On left side a large cyst came into view, filling up hypochondriac and lumbar regions. It extended from under surface of spleen obliquely downwards to just below level of umbilicus, and pushed the descending colon inwards. It was about 10 inches long by 5 broad at its widest part. It

was of hour-glass shape, the diameter at the constriction being about 2½ inches. Its anterior part was adherent to the abdominal wall by recent and weak adhesions. The finger could be passed behind these adhesions and along a small opening to the incision in the abdominal wall, midway between last rib and crest of ilium, in lumbar region. Firm adhesions bound the cyst to great omentum, pancreas, and stomach. Its upper end was continuous with hilus of spleen, in the substance of which there was commencing suppuration. Its outer covering was thick and fibrous; the inner layer, as usual, was smooth and glistening. It was completely full of daughter cysts, varying in size from a walnut to a pea. In the lower and outer part was a puncture, corresponding to the wound in the abdominal wall. Another cyst, the size of an orange, was attached to, but did not communicate with the spleen. This contained daughter cysts and milky fluid. In the hypogastrium was a third cyst, the size of a large foetal head. It was very tense, and contained hydatid fluid and a few daughter cysts. It was firmly attached to the base of the bladder and to rectum. In the great omentum and mesentery were about a dozen smaller cysts, varying in size from a mandarin orange to a pea. Along the abdominal wall, in right lumbar region, between the peritoneum and transversalis, was a cyst the size of an orange. The liver contained three cysts, two in the right lobe, one of which was attached to under surface of diaphragm. The contents of one in left lobe were bile stained. The largest of these hepatic cysts was about the size of an orange. Several small cysts, about the size of a pea, studded the under surface of diaphragm. Both kidneys were granular, and contracted. Capsule peeled up with difficulty; the outer surface was finely lobulated. On section, cortical portion lessened; numerous cysts (not hydatid), containing clear fluid, were found in both cortex and medulla. Both ureters were very dilated down to their entrance into bladder. The coats of that viscus were much thickened, and interior was somewhat sacculated.

I think this case worthy of record, both on account of the comparative immunity from severe symptoms, notwithstanding the rapid progress and wide extent of the disease, and the number of structures involved thereby; and also on account of the difficulty of diagnosis until the puncture on Nov. 5 revealed the character of the tumour. The autopsy clearly showed how ineffectual any serious operative proceedings would have been for the relief or removal of such extensive growths.

The fatal issue was unfortunately accelerated by the attempt to evacuate the largest cyst; but this proceeding was thought justifiable, notwith-

standing its risks, in view of the otherwise inevitable and fatal issue.

I have to thank Dr. Clark and Dr. Tarrant, under whose care the patient was, for permission to publish the case.

THE VALUE OF CONSERVATISM IN SURGERY.

By LOUIS FITZPATRICK, L.R.C.P., M.R.C.S.E., SURGEON TO THE QUEANBEYAN DISTRICT HOSPITAL, N. S. WALES.

ENCOURAGED by the philosophic maxim "We are never too old to learn," I venture to place on record the two following simple surgical cases which have recently come under my care. I am aware that they possess in themselves little importance, and do not, to the practising surgeon, appear very extraordinary. Nevertheless, they may teach the young practitioner, when he meets for the first time with similar cases, the great value of a strict conservative course in surgery. When a surgical case is brought to us for treatment or advice, we should recollect that eighty per cent. of those suffering from accidents belong to the labouring classes; and, before lifting the knife, we must also remember that to them every portion of the body is valuable—as by the labour of the body depends the existence of themselves and their families. More particularly is this the case when such parts of the body as the hands or legs, are the seat of injury.

Readers of surgical literature are aware that some most eminent surgeons frequently recommend the use of the scalpel, neglecting, at the same time, to advise the student to endeavour, to the utmost of his power, to save the injured member, or as much of it as possible. More especially should a strict effort to encourage conservative surgery be made at the present day when we have at our aid such powerful allies as the antiseptic dressings, lately introduced and brought to perfection by the energy and genius of Lister. As an example of what may be achieved in the conservative walk I shall mention the following:—

H. R., æt. 34, in the employ of the railway contractors, was splitting timber in the bush for building purposes. While thus engaged an ill-directed stroke of his tomahawk severed three of his fingers. That is, it cut clean through the flesh and bone, leaving the ends hanging by a thin piece of skin. He at once wrapped up the hand in a wet cloth, and hastily rode to my residence. On inspection I at once came to the conclusion to complete the amputation. He reminded me, however, of my duty by exclaiming "Oh doctor!

my living depends on my hands; without them my wife and children must starve." Twisting one or two small spurting vessels, I carefully replaced the severed ends, keeping each in position by a single silver wire suture. I then dressed the hand freely with lint, saturated in carbolic oil (1 in 20), and enforced perfect rest *for one week*. He appeared again before me at the expiration of that time, and to my delight and astonishment the parts had united. He has now a useful hand, the fingers being only very slightly contracted.

The following is another case more interesting perhaps:—

Mrs. H_____, æt. 30, when leaving her house on a dark night to fetch some water, missed her track, and fell to the bottom of a deep creek. When picked up she expressed great pain in the right knee, and was unable to move the leg. She was placed the following day in spring cart and brought to my house, seventeen miles distant, over a rough road. On examination, the region of the knee was found greatly swollen, red, and exquisitely painful. On the outer surface there was a cut evidently caused by a sharp stone. During manipulation a distinct crackling could be felt and heard in the joint. She received an order into the local hospital when she was at once placed in bed, and the knee enveloped in cold evaporating lotions. In a few days the swelling had sufficiently subsided to enable me to make a second examination in company with my colleague, Dr. Richardson. We both came to the conclusion that the case was a well-marked one of fracture through the knee joint, with rupture of the crucial ligaments and membrane. Some eminent surgeons have recommended amputation, and some excision in such cases. But I did not do either. The patient earned her living by washing, and required her legs as well as her hands. In order to give her a good, strong, useful leg I decided to produce, if possible, bony union or an ankylosed joint. The swelling having rapidly decreased I extended and straightened the leg, bandaging it well with rollers of lint. Along the posterior surface of the limb I placed a long narrow strip of steel one inch wide. The leg was then encased in a thick covering of plaster of Paris. For six weeks the leg remained in this extended position, and during that time she expressed herself as perfectly free from pain. On the removal of the dressings a thoroughly straight limb with a perfectly ankylosed joint was the pleasing result. She left for her home a fortnight after, and has since daily worked at her former occupation.

When we remember the tendency there exists after injured knee joints to a permanently bent and useless leg, the result of the above case may be considered satisfactory.

TRACHEOTOMY IN CROUP AND DIPHTHERIA, WITH NOTES OF FIVE CASES.

READ BEFORE THE N. S. WALES BRANCH
B. M. A.

BY WM. HY. CRAGO, L.R.C.P. LOND.,
M.R.C.S.E.

(1.) LATE in the evening of September 29th, 1884, I was asked to visit Rachel S—, aged 4 years, whom I had seen a few days previously suffering apparently from an ordinary attack of tonsillitis. At the time of my visit, about 9 p.m., the child's breathing was very harsh, and she was troubled with a brassy cough—her colour was florid—there being no cyanosis. On examining the throat I found the fauces generally very red but no diphtheritic patches visible on any part, the tonsils were not so much enlarged as when I had seen her a few days before, and she could swallow without difficulty. I ordered linseed poultices to front of neck and to upper part of chest.

Between 7 and 8 o'clock the next morning her father informed me that a decided change for the worse had taken place during the night, and that she could scarcely "get her breath." I told him to hurry home and hold a jug of hot water under her mouth so that she would breathe the steam. Following him as soon as I could I found the child almost asphyxiated, the face and lips being livid, respiration very shallow and difficult, the supra-sternal and supra-clavicular spaces being deeply retracted during each inspiration, and frothing at the mouth. Seeing that Tracheotomy offered the only chance of saving life, I hastily informed the parents, and, having received their consent, hurried off in a cab for a friend to assist me. Dr. Harper-Crwe at once accompanied me, and kindly lent me a tube and pair of blunt hooks for retractors to save me from going to my own house. On returning to the house we found the child still alive, but breathing with great difficulty, and evidently sinking fast. As she was perfectly insensible to pain, I at once proceeded to make an opening in the trachea. I need not trouble you with any details of the operation beyond saying that on reaching the fascia immediately surrounding the cartilages, I divided it transversely on the cricoid, and stripped it down after the manner recommended by Mr. Halke in a paper in the *Med. Chir. Trans.*, vol. LX., p. 92, copied from a German Treatise. (See foot-note, Holmes' Practice and Principles of Surgery p. 688, 3rd edition). I divided the cricoid and upper two rings of trachea and dilating the opening with Tracheotomy forceps, without much difficulty introduced the

tube, the air at once rushed in through the tube and almost immediately during an expiratory spasm a large piece of membrane was expelled through the tube. A feather was frequently passed through the tube to clear away any obstruction and to excite spasm, and in from five to ten minutes the pulse materially improved and the lips became a better colour, but nearly half-an-hour elapsed before her condition was at all reassuring. The blood that escaped during the operation was very dark in colour, and on dividing a small transverse vein running between the two anterior jugulars was pretty free, but was controlled by seizing one end with torsion forceps and holding the other end with an ordinary pair of dressing forceps. Soon after the operation I gave the child a little brandy and milk, which helped to revive her, and after an hour or two she became quite cheerful and swallowed nourishment freely. I personally cleaned the tube twice a day for a fortnight, and then once a day for three or four days, leaving it out for 10 minutes or a quarter-hour each day towards the last. The secretion that collected in the tube was of a very tough character for a week or ten days. The tube was altogether omitted on October 17th, 18 days after its insertion.

The first time the child heard her own voice after the operation she was quite terrified.

The wound in neck rapidly healed.

On December 6th, 1884, this patient had another attack of croup which was relieved by emetics and poulticing.

She is at the present time in robust health.

(2.) John R—, set. 28 months. I first visited this child on September 12th, 1885, at that time his tonsils were large and had on them two or three white patches; the temp. was 102°. As a sister of the patient had died a few days previously from diphtheria, I looked upon it as of that nature. I blew some Sulph. Sub. into the fauces, and ordered a mixture of Pot. Chlor. cum Acid Mur. Dil., and by the following day the white patches had disappeared and the child seemed much better, and by the 14th seemed so well that I discontinued my visits.

On Sept. 25th, i.e. eleven days after my last visit, I was again called in, and now found the breathing of a distinctly croupy character, each tonsil was covered with a white membrane (I should mention that between the two attacks the child had been apparently quite well, and playing about as usual up to the evening before my second attendance). I again blew in some Sulphur, and ordered that to be alternated with an application of Chlorinated Soda in Glycerine, and also ordered a mixture of Pot. Chlor., Acid Mur. Dil. and Vin. Antim. Tart. By 8.30 p.m. of the same day, the

membrane in the fauces was diminished, but the croupy breathing was more marked. I mentioned the probable necessity for tracheotomy, but the idea was not entertained.

During the following day, 26th Sept., I saw the child three times—the breathing became more and more laboured—there being great retraction of the episternal and supra-clavicular spaces during inspiration—there was still membrane on the tonsils. Towards night there was a troublesome cough, with a whistling sort of expiration, and at times great perspiration; child altogether in a very asthenic condition. I tried a few doses of a mixture containing Pot. Brom. and Chloral Hydrate, but as the membrane increased, went back to the old mixture. A cot was rigged and a jet of steam directed into it, impregnated with Ol. Eucal. Tracheotomy was positively vetoed by the parents.

On Sept. 27th, at 9.30 a.m., I found the respiration much quicker, and child very restless—throwing himself about in bed gasping for breath, the lips and fingers livid—abdomen working much with respiration. Not much membrane visible in fauces.

The parents consented to a consultation with Dr. Norrie, and to the performance of Tracheotomy if thought advisable. At 11 a.m. we met, and Tracheotomy being decided upon, Dr. Norrie put the child under the influence of an anaesthetic, and I proceeded to open the trachea; there was not much bleeding. I drew the isthmus of thyroid downward, and divided the upper two rings of trachea and the cricoid cartilage, and introduced a Cuzco's tube. Directly the tube was in a great rush of air took place, and a quantity of viscid mucus was expelled; for some time there was a spasmodic kind of expiration and blood and mucus were expelled. After about ten minutes the child's colour improved, but the breathing remained frequent.

3 p.m.—Respiration rather quick but not attended by any great noise; there is persistent vomiting, the child constantly pointing for a drink, which is no sooner swallowed than up it comes as if out of a pump. Ordered a Bismuth mixture, and lime water and milk. 9 p.m.—Breathing was very quick before cleaning the tube but afterwards became quieter, about 48 per minute. Vomiting all but ceased, but the child does not care to take anything; temp. $101^{\circ}4$, pulse 144. About mid-night a change for the worse took place, and death ensued a little after 1 a.m. on Sept. 28th, between 12 and 13 hours after the operation. The tube at the time being quite clear.

(To be concluded in next issue.)

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE B.M.A. MONTHLY MEETING.

Held at the Adelaide Hospital on August 26, 1886, the Vice-president (Dr. Davies Thomas) in the chair.

BALLOT.—Dr. Johnson was elected a member of the Brit. Med. Assoc., and of its S.A. Branch.

A letter was read from the University of Sydney asking for the co-operation of the Association, in conjunction with other scientific societies, in forming an Australasian Association for the advancement of science, the meeting to be held in Sydney during the year 1888 to celebrate the Hundredth Anniversary of the Foundation of these Colonies. The Association to be formed on the lines of the British Association.

Dr. Gardner, seconded by Mr. Jay, moved that the Branch express its willingness to co-operate as far as possible. Carried unanimously, and referred to the Council.

The Council having recommended that an Hon. Sec. should be appointed in connection with the Medical Committee, *re* the Jubilee Exhibition, it was unanimously decided by the meeting to ask Dr. Poulton to accept the position. Dr. Poulton having expressed his willingness to act, was duly elected.

Dr. Poulton read the following paper, giving some facts and statistics respecting the cases of enteric fever that had been received into the Adelaide Hospital during a certain period.

SOME REMARKS ON THE CASES OF ENTERIC FEVER TREATED AT THE ADELAIDE HOSPITAL DURING THE PERIOD FROM AUGUST 1, 1885, TO JUNE 30, 1886, WITH RECORD.

BY B. POULTON, M.D.

Mr. Vice-President and Gentlemen,—I am enabled, by the courtesy of my friends the President, Drs. Way and Hayward, Honorary Physicians to the Adelaide Hospital, to lay before you a short record of the cases of enteric fever treated there during a period of eleven months, when I had resident charge of the medical wards. This is but a scanty contribution to the history of Australian typhoid, but in bringing it under your notice I would venture to hope that a similar record may appear yearly; for the typhoid in the hospital is a fairly good measure of its prevalence in the city, and a good rough index of its incidence throughout the country.

In analysing this table one is first struck by the small number of cases treated during the season '85-'86, the total number being sixty-nine (69), a most significant fact, for, during the corresponding eleven months of '84-'85, there were treated one hundred and sixty cases. In 1881, there were treated 71 cases; in 1882, 159 cases; in 1883, 208 cases; in 1884, 224 cases; in 1885, 165 cases.

The admissions of city residents were, during—

1881...	...	...	...	29 cases.
1882...	...	...	...	75 "
1883...	...	...	...	66 "
1884...	...	...	...	81 "
1885...	...	...	...	59 "
Aug., '85-June, '86 (including the enteric season of 1886) ...	...	...	...	18 "

It is, of course, too early to establish a full comparison between the years 1881-1886; but as the cases admitted during the last six months of any year affect but slightly the total number, there is no doubt these two years will present some similarity in the occurrence of a small number of cases, and hence it is interesting to note that, during the year 1882, a beginning was made in connecting city houses with the newly established system of deep-drainage—a work which continued to progress throughout the city until 1885, when it was completed—so that the seasons immediately preceding and following four consecutive years, during which much upturning and emptying of old cesspits went on, stand out in marked contrast to those years from the much smaller number of enteric cases admitted to the hospital.

It is not, however, to be forgotten that, although the urban and suburban population was somewhat less during the last year under notice, the total number of indoor hospital patients remained about the same as in more populous periods.

I believe Dr. Corbin, and other members of this society, have drawn attention to outbreaks of diphtheria, following the disturbance of nightsoil.

These figures alone are, I think, sufficient to warrant the compulsory adoption of the fullest precautions suggested by science in such work; if not the temporary abandonment of tenements, especially large public buildings such as hospitals, during the alteration of drainage systems.

The sexes were about equally represented in the cases admitted. There were 36 males and 33 females.

Under 15 years of age	there were	9 cases.
From 15 to 20 years	"	18 "
" 21 to 25	"	19 "
" 26 to 30	"	12 "
" 31 to 35	"	6 "
" 36 to 40	"	5 "

From the city came 17 cases; from the suburbs, 32 cases; and from the country, 20 cases. The major part of the suburbs is not connected with the deep-drainage system. Some of the country patients were brought, I think, unnecessarily to the metropolis, passing hospitals on the way, to the risk of others and their own detriment.

The admissions were distributed as follows:—

1885.—Aug.....	2	1886.—Jan.....	6
Sept. ... 1		Feb. 7	
Oct. 0		March ... 9	
Nov. 1		April ... 22	
Dec. 6		May 18	
		June..... 2	

Patients had generally been ill about seven days on admission. The total duration of illness was never under three weeks (except in fatal cases), and the residence in hospital was generally five or six weeks, patients being always kept in until convalescence was well established and meat diet in use for some days.

Diarrhoea was present in 37 cases, absent in 32 cases; spots were noted in 47 cases. Eight cases relapsed.

The average highest temperature was 104°; the highest actual temperature registered in axilla was 107°, in a girl of 18 years of age, who ultimately recovered.

Of complications: there was more or less pulmonary congestion in 14 cases, including 7 cases of pneumonia, and melena in but 4; periostitis tibiae as a sequel in 3; epistaxis in 2; bedsore in 1; abscess of cellular tissue in 2. There were 3 deaths, or 4·347 per cent.

During the five (5) years 1881-1885 there were 827 cases and 101 deaths, or 12·212 per cent.

It may be mentioned that during the period under review 15 cases of febricula were treated in the hospital, some of which were probably mild cases of enteric fever.

The medicinal treatment, except in some cases where reputed antiseptic remedies were exhibited, was of the simplest.

The haustus ammoniae acetatis of the Hospital Pharmacopœia was given in almost every case as long as the fever lasted; in hyperpyrexia, quinine in large doses was given with varying success; I think, as a rule, the use of ice bags to the head, and the application of sheets wrung out of cold water to the whole body, proved the most satisfactory methods of reducing a very high temperature. Bathing I did not resort to, except very rarely, the appliances being somewhat deficient. Syrup of eucalyptus rostrata proved of great benefit in too copious diarrhoea. Chloral and morphia were occasionally used in delirium and sleeplessness.

The routine diet adopted was, three (3) pints of iced milk, diluted with soda water, daily, until the temperature was much reduced; then broth or beef tea was added to the diet scale; subsequently a little arrowroot, with bread and milk, or rice, only after a normal temperature had been established some days. The patient was not, as a rule, allowed to eat meat or vegetables for a good fortnight or even more after the subsidence of fever.

Difficulty was sometimes experienced in getting air or water beds for patients threatening to develop bed sores; and I take this opportunity of emphasizing the great, but apparently unrecognised, value of spring wire mattresses in the treatment of fever, phthisis, and many chronic diseases. Air and water beds don't last in this climate; galvanized wire mattresses are long wearing, clean, cool, cheap, and elastic, and should, I think, be used throughout the medical wards, and for many surgical cases also. It is probable that the convalescence of these typhoid patients would in some instances have been expedited were the medical wards on the ground floor, or some easy means provided for moving their beds into the garden, especially as the wards at night are not infrequently close and stuffy.

In concluding it is pleasant to be able to comment favourably on the very great interest taken by the nursing staff in their fever patients; to their persistent anxious care and attention is in great measure due the good results now placed before you, and constantly have I lamented that these good women are hampered in their proper work as nurses, by having also to perform the unsuitable work of scrubbing the floors of wards and passages.

The following query from Mr. Bickle was read:—

A B S O R P T I O N O F A L V E O L U S.

BY L. W. BICKLE, M.R.C.S. ENG.

Recently I was consulted by a gentleman suffering from violent toothache. The offending member appeared sound, and as it was night when he came, I merely gave him a sedative. The next day he came again, having slept after the draught, but with a recurrence of his old enemy on waking.

On examining the tooth carefully, I found it to be the first upper molar, the appearance peculiar, the gums having receded, exposing the neck and upper portion of the fangs. A probe introduced between it and the bicuspid passed into what appeared to be a large hollow, so big that I expected it must be between

the fangs. I gave it as an opinion that from some cause or other the tooth was quite dead, but that it would be better to try and stop the pain as the grinding surface was perfect. Efforts proving useless, I extracted it, the patient experiencing immediate relief. The tooth was quite free from decay, but the fangs were evidently dead, the internal one especially being absolutely dry and dark, and completely divested of the periosteal layer. The other fangs were showing signs similar, but much less marked. The fangs were much more widely separated than usual, and the alveolar process between them was so large as to give the patient the idea that there was another tooth coming down.

My object in stating this case is to enquire whether any of those present have met with a similar case, as I do not remember having met with one before. Further, was I right in extracting? I believe I was; the immediate relief (which has proved permanent) clearly shows that this was the cause of the pain. But why? What should have induced these changes in the fangs, the crown being perfect?

The second molar on that side had been extracted a few days previously by a dentist.

REMARKS BY MR. RODWAY.

The case referred to by Dr. Bickle is one of absorption of the alveoli. It is really a premature occurrence of what takes place in extreme age, no matter whether one tooth only, or many, or all the teeth, are affected. It is very easy in probing for interstitial decay to be misled by getting the probe between the bare roots, and so apparently finding a distinct cavity in the tooth.

The appearances mentioned are what we always get in absorption of the alveoli, and Dr. Bickle has noticed them with great accuracy. One root, or all the roots appear dark, sometimes almost black, frequently transparent like horn, owing to the near approach to complete calcification of the dentinal fibrils. The roots are devoid of periosteum. In such cases the inner fang (that is to say the palatal, if it be an upper molar), is *always* affected, the buccal may or may not be. I have never seen the buccal roots dead and the palatal left healthy, whilst it is very common to see the reverse, i. e., the palatal dead and the buccal healthy.

The remark that "the alveolar process between them (the roots) was so large as to give the patient the idea that there was another tooth coming down," applies to all such cases, because in alveolar absorption the outer and inner plates both waste away, but the bone immediately under the tooth and between the roots does not do so, therefore when the tooth is removed, as all sides are gone, a cone of bone is left standing, representing the triangular pyramid between the three roots, and the patient will often fancy that either a new tooth is coming or that part of the old one was broken in, in extracting. The removal of the tooth was the right and only course to follow; in fact it was trying to drop out itself, which it would have succeeded in doing, after giving perhaps a year or two more pain.

Causes.—There are several causes for the change Dr. Bickle saw in the tooth.

First.—The chief and most common is "*density of structure*," hence we usually see sound splendid teeth lost in this way. As life advances our teeth become more dense, and in those who start life with very good solid teeth, frequently in middle life, and always in old age, they have become so much more dense, by calcification of the dentinal fibrils, and obliteration of the pulp by the formation of secondary dentine, that they lose all vitality, and so being to all intents and purposes dead (*i. e.* foreign bodies), nature throws them off by taking away their sockets, pain then ensues from inflammation under the tooth, the same as would around

a piece of dead bone, if you constantly kept working it about and pressing on it, as in the case of a tooth.

Second.—*Loss of the opposing teeth*, for as soon as teeth are extracted, having nothing to strike against, those left soon begin to rise in their sockets, which also waste at the same time, and soon the teeth are so exposed as to lose all nourishment and consequently die. Sometimes they will grow down so far as to touch the opposite gum.

Third.—It may be a family peculiarity. I have seen it occur as early as nineteen (19), and each member of that family showed signs of the same disorder.

Fourth.—It may be, and frequently is, due to neglect of ordinary cleanliness. Tartar is allowed to accumulate, and creeping under the gums will cause destruction of the sockets.

Fifth.—I believe it always follows severe mercurial salivation, although years may pass before signs are noticed. It is very slow in its progress, and often will seem to be arrested for some considerable time. We cannot prevent it, but extreme care in cleaning the teeth will certainly delay the loss of them.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 59th General Meeting of the Branch was held in the Royal Society's Room on Friday, 5th November, 1886, at 8.15 p.m. Present—Dr. Knaggs (President), Drs. Clubbe, W. Chisholm, Hankins, Fiaschi, Quaife, O'Reilly, Maher, Watson, Ellis, Chambers, Rowling, Musket, West, Parker, Worrall, Brady, Roth, and Crago.

The minutes of the previous meeting were read and confirmed.

The PRESIDENT announced the death of Dr. W. F. Mackenzie since the last meeting of the Branch.

Dr. QUAIFE proposed and Dr. ROWLING seconded, "That a letter of condolence be written by the President to Mrs. Mackenzie."—Carried.

The PRESIDENT reported that the sub-committee appointed to deal with the subject of "Tests of Vision in the Mercantile Marine Service" had brought up a report which would be forwarded to the Marine Board and the Colonial Secretary, as set forth in the resolution.

Dr. ROWLING read some notes on "A case of varicose veins over the whole surface of the body." The patient was exhibited and examined by the members.

Mr. HANKINS proposed and Dr. PARKER seconded, "That a sub-committee of three be formed to examine and report fully upon this case. That Drs. Knaggs, Quaife, and Rowling form such sub-committee."—Carried.

Dr. ELLIS explained a case of "Fracture of the patella."

A discussion ensued, in which Mr. Hankins, Drs. Roth and Knaggs took part.

Dr. MUSKETT read a paper on a case of "Unusual site for hydatid cyst—an addition to the recognised varieties of intra-scrotal disease."

Dr. CHAMBERS read some clinical notes on three cases of general interest:—(1.) Umbilical hernia, with removal of eighteen ounces of omentum. (2.) Malignant disease of kidney. (3.) Fibro-cellular disease of parovarium;—and exhibited drawings of each case.

Mr. HANKINS said he quite agreed with Dr. Chambers' remarks as to the effects of the hot winds on surgical cases of all classes. With regard to the second case mentioned, he (Mr. Hankins) had had a somewhat similar case under his care in hospital.

MEDICAL SOCIETY OF QUEENSLAND.

A MEETING was held at the Brisbane School of Arts on 9th November, 1886. Present : Dr. Bancroft in the chair. Drs. W. S. Byrne, Gibson, Hill, Little, Love, Lyons, McNeely, C. F. Marks, Mullen, Hon. Dr. Taylor, and Dr. Rendle (Hon. Sec.) Drs. E. H. Byrne and Hare were present as visitors.

The minutes of last meeting were read and confirmed.

The following candidates were nominated—

Augustus Charles Shout, M.R.C.S. Eng., 1852, L.S.A. Lond., 1853, by Dr. Rendle and Dr. Gibson. Edward George Keighly Marks, L.K.Q.C.P.I., 1876, L.R.C.S.I., 1875, M.D., M.S.Q. Univ. Dub., 1876, by Dr. Rendle and Dr. C. F. Marks. Edward Henderson Byrne, L.M. & L.S. Univ. Dub., 1875, by Dr. Little and Dr. Lyons.

A paper was read by Dr. Lockhart Gibson, being the first part of a paper, entitled "The Blood forming Organs and Blood formation," an experimental research which had been presented to the medical faculty of the University of Edinburgh in April, 1885, as a graduation Thesis, was awarded a gold medal, and published in the *Journal of Anatomy and Physiology*, 1886. It formed a suitable sequel to the paper on Pernicious Anæmia, read by Dr. Love, at the last meeting of the Society, and opened up similar lines of discussion.

Dr. GIBSON confined himself to the elements found, or said to be found, in the blood in addition to the red and white corpuscles, stating that it was necessary to come to a clear understanding with regard to these before the blood could be studied from either a clinical or a developmental standpoint. These elements are three or, Dr. Gibson thinks, four in number.

1st. Nucleated coloured corpuscles (corpuscles of Neumann), identical with those found in the blood of the foetus, occasionally also in the circulating blood, and always in the red marrow of bones throughout extra-uterine life. These are regarded as the only fore-runners of the non-nucleated red corpuscles, as will be shown in subsequent parts of the published paper.

2nd and 3rd. Two elements, best named microcytes, distinguished into coloured and colourless. They include the haemato blasts of Hayem and Pouchet, and the Blut-plättchen of Bizzozero. The haemato blasts include both coloured and colourless, the Blut-plättchen only the colourless. The view taken is that the coloured microcytes are broken down red cells, and the colourless microcytes are most probably fragments of the nucleus of a nucleated red cell. Hayem's view that the microcytes are developing red cells was strongly condemned. The important action of the colourless microcytes in inducing coagulation was dealt with and strongly supported.

4th. The invisible corpuscles of Norris were only referred to, and were stated to be red corpuscles which have, either partially or entirely, lost their haemoglobin, owing to the methods employed by Dr. Norris.*

Dr. BANCROFT, opening the discussion, said it is very interesting how the red cells come to be formed. In cases of cysts connected with the Lymphatics, not infrequently seen in Brisbane, the fluid removed, after standing, deposits about one-twentieth of red coloured sediment and in this the microscope shows concavo convex bodies, the size of blood cells, which roll about but do not cohere. These probably are the young of blood cells. In connection with what Dr. Gibson said about the colourless microcytes not staining until after the blood has been drawn for a time, and in support of his idea that they stain more easily after death, I may mention that the worm *Filaria immitis* of Leidy, from the dog's heart, does not stain if living, but when broken and dead becomes stained with the blood in which it is immersed. In pregnant women, affected with *Filaria*, the blood of the foetus is free from embryonic *Filaria*, indicating that the foetal blood cells have not been derived from the maternal blood.

Dr. LOVE wished that Dr. Gibson had told us more about the origin and fate of the red cells, the research was valuable if it did no more than help us to differentiate the cellular elements of the blood. According to the simplest view blood formation might be briefly summed up by saying that the white cells were produced in the spleen, lymphatic glands, and bone marrow, and were transformed into red cells passing through an intermediate stage. In health there seemed to be a standard or maximum of red cells beyond which it did not seem possible for the number to pass, namely, about five millions of haemocytes in a cubic millimetre, but it was not so with the white cells. It was interesting to compare the results of disease on the blood-forming organs and results that would be expected in the blood with what was actually known to follow such disease. In atrophy of spleen and lymphatic glands one would expect to find diminution of leucocytes and red cells, and it was so. In hypertrophy of spleen and lymphatic glands one would expect increased numbers of leucocytes and red cells. The leucocytes are increased, but not the red cells, which are proportionately diminished. Whether this was due to interference with formation or to increased destruction of red cells is at present a mystery. Again, we might expect a state of things in which the processes of transformation were exaggerated, where there would be increase of red cells with corresponding decrease of white, but this never occurs. Applying these data to pernicious anæmia, we must conclude that as there is no evidence to show either deficient production of red cells, or diminished transformation of red into white, then there must be increased destruction of red cells. Many facts in the pathology of the disease support this view, namely, pigmentation of skin, excess of pigment in urine, presence of debris in the blood, and presence of iron in the liver, probably derived from destroyed red cells.

Dr. LITTLE hoped that Dr. Gibson would not feel hurt at his saying that such papers as this gave us little or no information, being very difficult to follow without careful reading ; he would like to see papers more practical and less scientific.

Dr. HILL, while agreeing to some extent with Dr. Little, thought papers like this were necessary, it being essential for men in practice to be kept acquainted with the most recent and advanced knowledge, especially in physiological subjects.

Dr. RENDLE confessed to being unable to follow and understand the greater part of the paper, on account of its abstruse nature and the number of technical terms used, yet he thought the question had many

* See Paper by Dr. Gibson in *Journal of Anatomy and Physiology*, July, 1884.

practical bearings, and one of the principal objects of the Society was to keep us acquainted with advancing knowledge. The paper was very interesting in spite of its technicalities. The idea of special processes and special organs for the destruction of red corpuscles seemed strange were not the vital processes of tissue change sufficient to account for disappearance or destruction of corpuscles. Why were destruction particles found in the blood current? one would only expect them in the tissues or absorbents. Surely coagulation ought not to be dependent on a destructive process; it was a reparative process. Might we not with advantage use the term change instead of destruction. Were we to regard iron as arresting the destruction of red cells rather than as helping in their formation?

Dr. TAYLOR having arrived late could not review the paper as he would like, but after glancing through it and hearing the latter part, thought it did not seem to deal with some essential elements—the formation of adult red corpuscles. He referred to the nucleated red corpuscles formed in the vascular area of the embryo from mesoplasmic cells, and to this giving place at an early period of foetal life to the non-nucleated red corpuscles, but how and when the adult red corpuscle was formed the paper did not appear to throw much light beyond the usually received opinions. The views of Hayem regarding the Hæmatoplasts were not generally received. The Plättchen cannot be identical with the marrow cells as they contain no nucleus. If, however, these Plättchen were broken down red corpuscles we should find an excess of them in the spleen and blood of the splenic vein, great destruction of red cells taking place in the spleen. On this point the paper was not clear.

Dr. GIBSON in reply said, Dr. Bancroft's observations on chyle cysts are most interesting, and confirmatory of some experiments of mine on lymphatic glands. I endeavoured, by tying the thoracic duct in the neck of a dog, to produce stasis of the lymph in the lymph glands, and find whether any of the lymph cells when so kept in the glands pass on to form red cells; the results were affirmative. I have little doubt that some of the cells mentioned by Dr. Bancroft were young nucleated red corpuscles. In reference to Dr. Little's remarks, I am sorry the subject was somewhat too physiological, but I expected that some cases would have been first shown, and that a change from the practical to the scientific would not be uninteresting. Moreover, a thorough knowledge of the physiology of the blood is very necessary. The paper took a longer time to read than I thought it would. In answer to Dr. Rendle, there are cells in all the blood-forming organs, especially in the spleen and bone marrow, which appear to assist in taking up the fragments of broken down red cells; this is referred to in a later paper. In answer to Dr. Taylor, Dr. Gibson said Dr. Taylor did not hear the greater part of the paper, and could not comprehend its meaning by glancing over it, and this his remarks showed. Apart from my own work I consulted original papers only, and, as the paper is an original one, I hope it is in advance of information given in the latest edition of Quain, from which Dr. Taylor seems to have quoted.

The CHAIRMAN then made a few further remarks in reference to blood-letting, that it was not so foolish a proceeding as we had come to regard it, and that we had gone to an extreme in giving it up. In many cases where bleeding was now thought to be unwarrantable, great improvement often followed an accidental haemorrhage, as in some cases of haemorrhage in typhoid fever. Perhaps, by further study of this subject, we may find out when bleeding was likely to be of use.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, DECEMBER 15, 1886.

EDITORIALS.

THE TIMARU (N.Z.) POISONING CASE.

AFTER a trial, lasting eight days, which terminated on October 19th, Thomas Hall, a man of some social position but in embarrassed pecuniary circumstances, was convicted of an attempt to poison his wife, at Timaru, N.Z., by means of tartarized antimony, and sentenced to imprisonment for life. Margaret Graham Houston, who had resided in his house as a companion to his wife, was arraigned with him, but was acquitted, the jury saying that in their opinion she left the court without a stain upon her character. The object of the crime, for the attempt at which Hall was found guilty, was to obtain £6000, for which sum he had insured Mrs. Hall's life. His criminal design was frustrated by the professional acumen and vigilance of Dr. McIntyre, of Timaru, who was the medical attendant on the lady. His suspicions having been aroused, he took away samples of the food, drink, vomit and evacuations of the patient, which, on their being submitted to analysis, showed evidence that they contained antimony in considerable quantities. On this being ascertained, Dr. McIntyre, on Sunday, August 15, went to Inspector Broham, the officer in charge of the police at Timaru, and told him that he had strong suspicion that Thomas Hall was poisoning his wife. The police officer requested the doctor to swear an information of the fact, and on this a warrant was granted for the arrest of both Thomas Hall and Miss Houston. Some discussion has taken place in New Zealand with regard to this proceeding, and it was asserted that the police inspector at first delayed to act in the matter with sufficient promptitude. This, however, has been set at rest by Dr. McIntyre, who in a letter to the *Timaru Herald*, dated Oct. 22, exonerates the inspector, and says that he acted within a few minutes of receiving the infor-

mation. A matter of special importance is, however, the question whether the legal information, which it is necessary to be sworn to by some person prior to the granting of a warrant, should be the act of the medical man whose suspicions have been aroused, and who has informed the police authorities, or by these functionaries themselves. We are strongly of opinion that the public interest requires that it should be invariably done by the latter, whose duty it is to step in and take all due steps necessary for the prevention or detection of crime on receiving trustworthy information. The police in such a case might fairly demand that the circumstances should be stated to them in writing signed by the informant, and this document should be considered a confidential communication unless the exigencies of the public good required otherwise. On this the police officer should swear the information and obtain the necessary warrant, the original informant, of course, being called as a witness in the case to give evidence. It is manifestly unfair that all responsibility should be thrown on the medical man when acting in the public interest in such cases, for, though the action may have been taken with the utmost good faith, it is always possible that suspicions of secret crime are incapable of proof, and though the victim's life may have been saved, and the crime prevented (for no murderer would be so reckless as to proceed in his design on attention being called to it), the doctor may have laid himself open to a civil action resulting in his ruin. This is not the case with the police, who, if they act in such a case on reasonable information, are entitled to support and defence by the government whom they serve. A medical man may have suspicions which would reasonably justify confidential information being given to the police, who could make proper enquiry and take fitting action on it, which might yet not be sufficient for him to take independent action, which in the event of failure, would perhaps be his pecuniary and social ruin. As a consequence, he would have to wait a longer time to confirm his suspicions into something like certainty before he took action, the patient's life being in peril the whole time. In this case Dr. McIntyre's courageous action has been fully justified by the result, and we are pleased to hear that it is to be recognised in a substantial manner by a public testimonial. The Insurance Companies, as in duty bound, are, we hear, subscribing liberally, the Australian Mutual Provident Society which, had the crime been successfully carried out, would have been mulcted £6000, subscribing, we are informed, one hundred guineas. For ourselves, we may say that we are proud of Dr. McIntyre as a professional brother, and return him the thanks

of the profession for the credit reflected on it by his bold yet prudent action. We would call the special attention of our readers in New South Wales to this case, and point out to them the patent fact that from his point of view Thomas Hall was very unfortunate, in so far as that under the circumstances he resided in New Zealand, where proper precautions are taken with regard to the practice of medicine, and where certificates as to the cause of death are only received from registered medical practitioners who have given proof that they have received a proper professional education. Had he resided in New South Wales, he might have carried out his designs with but little chance of detection, by the aid of one of the numerous uneducated men who are practising medicine in it, unchecked by any regulations, and whose certificates as to the cause of death are received by the registrar-general and his subordinates as all sufficient. In all probability no suspicion would have been aroused in the heaven-inspired practitioner's mind, and, as men practising without medical training can be endowed with but little conscientiousness, even if he did detect it, it is but reasonable to suppose that his feeble conscience would not very strongly impel him to inform the authorities of his suspicions; whilst if he did, of what value would be his evidence in a court of justice, even if he were not turned mentally inside out by a clever barrister for the defence. With all due deliberation, and thoroughly believing what we state, we are confident that numerous cases of criminal poisoning occur every year in the senior colony, which are undetected in consequence of the utter absence of any precaution on the part of the government, to ensure that no body shall be disposed of until the cause of death is certified to, by some person whose opinion in such a matter is of some authority.

THE REGISTRATION OF BIRTHS AND DEATHS IN NEW SOUTH WALES.

SINCE our last issue the report of, and evidence taken by, the Select Committee appointed by the Legislative Council of New South Wales on June 10th, for the purpose of enquiring into the state of the laws in relation to the registration of births, deaths, and marriages in that colony, of which committee the editor of this journal was chairman, have been distributed to Members of Parliament and to the press.

The lay newspapers have already favourably commented on the action of the committee, and have, in various leading articles, expressed the opinion that its labours have exposed a state of things which casts grave doubts on the safety of

human life in the colony, so far as such safety is dependent on the detection or prevention of crimes which would be, perhaps, exposed by fit enquiry prior to the registration of a death. They say that a change in the law is absolutely necessary, and logically must follow the exposé brought about by the committee's enquiry. We intend to return to the subject in a future issue, but for the present content ourselves with reprinting the following portion of the report relating to the procedure in cases of births and deaths, which is of especial interest to the profession :—

" We find that the present regulations under which births are registered are not satisfactory, in so far as they do not provide that the facts relating to the birth shall be vouched for, either by a declaration or by the evidence of an independent person ; further, we think that the period of sixty days allowed for the registration of a birth is unnecessarily long, and that under the present state of the law it is impossible, in those cases in which the parent or parents have neglected to register the birth until after the lapse of six months, to repair the error. We think that provision should be made by which a birth, notwithstanding any delay which may have occurred, should be capable of being registered.

" We also find that no provision is made for the registration of the births of any still-born children, and we believe, from the evidence which has been given before us, that this circumstance affords facilities for the concealment of crimes against the lives of young children. Although the existing law does not require any record to be kept of the birth or burial of any still-born child, this omission is, to a slight extent, remedied by the action of some of the cemetery authorities, who require a certificate from either the doctor or the midwife who attended the mother at the birth, that the body of the child proposed to be buried was still-born. The great majority of the certificates given in such cases by midwives are evidently written by very illiterate persons—many of them are only signed by a mark, often unwitnessed ; others bear evidence of having been the production of more than one person—and, as a precaution against the concealment of intentional foul play, can be of but little value. Large numbers of these certificates have been handed to the Committee by witnesses examined as being connected with the management of various cemeteries in the neighbourhood of Sydney, and of these certificates we have selected some few to be added as an appendix to this report. Three of these are of especial interest, as, though professing to be given by one midwife, there is considerable reason to doubt their being in the same handwriting ; whilst one of these, viz., that relating to the child of Mrs. Wells, said to have been still-born, was the authority upon which the child of a single woman named Wells, who lived at Lane Cove, was interred, having died at the age of two months, under circumstances which called for enquiry.

" We find by the existing Act, and the regulations under it, that on a death occurring it is not necessary for it to be registered prior to the burial of the body, and that this can be done at any time until thirty days have elapsed after the decease. We are of opinion that this affords facilities for the concealment of crimes against life, which would be lessened were it rendered obligatory for the death to be registered prior to burial. Provided, that in cases where proper explanation is made, showing that unavoidable circumstances rendered

this impossible, no penalty should be enforced for such neglect to register. Evidence was given by various witnesses that the bodies of persons who came to their death by violence might, under the existing regulations, be disposed of without arousing suspicion. One witness, in his answer to question 1025, says :—' I have heard an undertaker say that he could dispose of as many bodies as he liked without anybody knowing anything about it.'

" We find that though under the existing Act there is no power given to the registrar to demand a medical certificate of the cause of death, and that he is obliged to register it on the information of the tenant of the house in which the death occurred without any such certificate, yet the majority of the registrars do illegally demand such a document, and, failing its receipt, refer the informant to the coroner or the police.

" We are of opinion that a matter of so much public importance as this should not be left to the independent will of the various persons who may happen to be registrars, but that all should be guided alike by a universal rule.

" We, therefore, are of opinion that, in all cases where a legally qualified medical practitioner has been in professional attendance on a deceased person, it should be his duty to furnish a certificate of the cause of death ; and that in those cases in which no legally qualified medical practitioner has been in attendance on a deceased person within a reasonable time preceding the death of such person, it should be reported to the officer in charge of police in the district in which the death occurred, who should thereupon make due inquiry, and if he is satisfied that no suspicious circumstances existed in relation to such death, should give a certificate that, having so inquired, he found no reason to doubt that the death was due to natural causes. We make this recommendation in the belief that it is necessary for the public safety that there should be some rule fixing from what persons certificates as to the cause of death should be received ; and we think that, failing a certificate from a legally qualified medical practitioner, who by virtue of his diploma has given proof that he is competent to give such certificate, none should be received, except from a police officer, as before recommended. We are of opinion that no death should be registered unless the information of the death furnished to the registrar is accompanied by one or other of these certificates, and that, failing one of them, a coroner's inquest or magisterial inquiry should be held. We are of opinion that the correct compilation of vital statistics, and their prompt transmission to the health authorities, is highly important, and that the evidence given before us goes to show that there is room for very considerable reform in both particulars."

A VACCINATION CASE BEFORE THE COURT IN VICTORIA.

A CASE, which came before the Police court at Prahran, Victoria, is of some professional interest. A man, named Frank Moore, was summoned for neglecting to have his child vaccinated. It appears that the child had been some time before, vaccinated by a veterinary surgeon. The father, when warned by the police, took his child to the district vaccinator, who examined it, and, it is to be presumed, found evidence that the

operation had been sufficient, as he declined to re-vaccinate. He very reasonably also declined to give a certificate of successful vaccination, for he, of course, could only properly certify to the result of his own action.

We think the prosecution of the man was, under the circumstances, ill-advised, and that, though declining to give a certificate, the district vaccinator might have informed the police that, in his opinion, the child was sufficiently protected. As the prosecution had been instituted, we think the dismissal of the case by the magistrates was wrong, for the law was clearly broken, and a small fine should have been inflicted. Vaccination should be performed only by such persons as have received a proper training for the purpose, and not by any amateur, who, in his self-sufficiency, considers himself competent to do it. The mere operation is nothing, and may be done by the most crapulous old woman; the important matter being the fitting choice of the lymph used, the due observation of the stages of the vesicles, and the true success of the result.

[CONTRIBUTED.]

THE CARE AND TREATMENT OF THE
INSANE.

(Continued from page 52.)

Acknowledging the necessity at a certain stage in the development of a psychosis, for the removal of the patient to an asylum from surroundings having a causal or otherwise injurious relation to his mental condition, it does not follow that such a course includes all that is necessary or desirable in the interests of those liable to lose their mental balance. There must be an earlier stage than that at which it is found necessary, for safety, to send lunatics to asylums, when the symptoms exhibited should be apparent to medical men as indicating mental inequilibrium. Such premonitory symptoms, not being so serious as to justify restraint and removal of the patient from his home, might surely be correctly diagnosed and dealt with on general principles of treatment by the ordinary practitioner, who would not require the knowledge of a specialist where preventive measures would probably be of greatest importance. If the obviously insane have a moral right to State protection and supervision, those who have not yet reached that stage may fairly demand of

the profession an intelligent recognition of their mental condition. Symptoms occurring in the pre-asylum stage, of which we as yet know little for want of intelligent and systematic observation, cannot be presumed to be in all cases suitably treated by the means directed against more fully developed symptoms in asylums. As a matter of fact, however, practitioners are not unfrequently consulted about mental symptoms, which yield to treatment of the simplest sort, whatever may be the view taken of them by the medical man. There is no doubt that some cases can be treated at home, if care only be taken to remove unfavourable conditions from the patient; but in a much larger number it is necessary to remove the patient to entirely new surroundings. Many of the cases met with in general practice show as one of their symptoms a marked antipathy to particulars persons, the odium existing between those standing to one another in the closest degree of intimacy, as husband and wife. It is in connection with this striking fact that removal from home is so essential in many cases; but it is not, perhaps, the inanimate surroundings of the patient that constitute the objectionable element so much as the persons who share the residence with him. A simple change of residence, if the patient is not haunted by the obnoxious attendants, may be the chief factor in the cure that follows. With this aversion for some, there may exist as decided a preference for others, who in such a case would prove the best attendants. The beneficial effects of change of surroundings are doubtless largely due, in the majority of cases, to the removal or modification of those conditions having a causal relation to the mental disorder.

While striving for the application of remedial measures early in the course of mental disease, it will of course be necessary to guard against commitment to an hospital without adequate reason. The mere fact of the existence of mental aberration will not suffice for the detention of a person against his will. We must consider what circumstances should guide us in determining the necessity for hospital treatment, as distinguished from more simple treatment at home. Much would depend on the cause of the alienation: if it depend on bodily conditions, the family physician would have an advantage over specialists themselves, because he might reasonably be expected to cope successfully with it as part of the constitutional state. On the other hand, some physical condition may have lighted up hereditary insanity, when it would be doubtful if removal of the exciting cause would relieve the mental symptoms, though of course it would be the first step to take towards that end. In other cases, as dipsomania, restraint would appear to be necessary from the

beginning, though the morbid craving may be prevented by simple treatment applied early enough. Proposals have been made for the establishment of hospitals for the insane, in which the patients could be attended by their own physician ; but if the family doctor should be thought competent, it would rather be only in the earlier pre-asylum stages of mental affections, when a change of residence, with little or no restraint, is all required, in addition to treatment on general principles.

The deprivation of liberty and the stigma accompanying it—so lightly carried out in every case under the present system—is a step that does much towards filling the asylums with incurables. It repels patients from the only recognised means of treatment till the disease is confirmed and incurable ; whereas a system of lunacy regulation, if really intended for the benefit of the insane, would rather attract patients in the earlier stages of their malady, when they were moveable to take a rational view of their now case, and when treatment would be followed by the best results. The establishment of hospitals for recent cases in which insanity would be observed and treated in a professional manner without any legal certification of the lunacy, except for legal purposes, would be a great boon. Such an arrangement would permit us to look forward to the time when patients suffering from mental derangement will act on the advice of their ordinary attendant or their friends, and place themselves under treatment in hospitals or retreats without any legal ceremony, though under due supervision by State inspectors. Many of the incipient insane are well aware their ideas are morbid, though quite powerless to escape from their relentless presence ; but the fear of ridicule and the odium attached to even the suspicion of insanity effectually prevents them acknowledging it or subjecting themselves to the risk of its being found out. As long as this is the case the necessity for privacy in all asylums will be apparent.

The existence of danger to the patient himself or to others would, of course, justify forcible detention. In milder cases in which the symptoms were harmful or likely to become so though not dangerous, the person so affected, if at large and appearing not to be under proper care—supposing certification to be resorted to only when proved to be necessary—might be called upon to show cause why he should not be placed under restraint for purposes of treatment, anyone interested taking the responsibility, under penalties on failure to establish his contention, of swearing an information to that effect. If it could be shown that the interests of the patient or his relatives were suffering through his state of mind,

or that he was incapable of judging his own need for treatment, he could be detained as a neglected lunatic though certification might not be necessary. Such a course could be followed, supposing certification and forcible detention to be reduced to a minimum, and voluntary submission to treatment to be frequently resorted to in the earlier stages. When there is no hope of improvement, detention in an asylum should depend on the probability of danger, inconvenience, or scandal if the patient were allowed to be at large. But all degrees of restraint ought to be recognised, so as to suit individual cases.

If asylum life has the effect of reducing the health of the attendants, it must also be productive of an incalculable amount of harm to a large proportion of the inmates, whose whole nervous system is often deteriorated, and stands more in need of bracing outdoor exercise and other hygienic measures than that of their sane co-dwellers. If seclusion and restraint are thought so objectionable, why is not also the common restriction of liberty within the walls of the asylum avoided and kept within the narrowest possible limits ? Locked doors are only a milder form of seclusion and restraint, yet no steps are taken to reduce the evil. Patients are more likely to look upon the asylum as their home and to return gladly to it, as they would to their own homes, when they have been relieved of the feeling of imprisonment ; and the system of unlocked doors, wherever tried, has been followed by marked improvement in the health of the inmates. The number of attendants may require to be increased, but there are other good reasons for such a step. The feeling of imprisonment must have a very baneful effect on the unstable minds of lunatics, and a measure of freedom may be of more value to some as a therapeutic agent than the bodily comforts usually provided for them. Exercise and diversion even, or any of the other means of treatment may be of less importance than liberty, the denial of which causes extreme dissatisfaction in almost all cases, sets the inmate against those who act as his gaolers, and tends to render all measures for his improvement unavailing. The instinct of freedom is hard to kill, as anyone will find in walking through the wards or airing-yards of an asylum, when pitiful appeals for release are made at every step from patients in almost all stages of mental decay. It is not merely for the sake of the general bodily health that greater freedom is desirable, but also to remove a mental cause of disturbance which acts injuriously on mind and body alike. Liberty, indeed, may be made a potent therapeutic agent when judiciously applied according to the nature of each case.

We hear sometimes of "asylum-made" lunatics—patients whose insanity, beginning perhaps with curable and transitory symptoms, has become indelibly impressed on them by the insanitary surroundings of the asylums. But we cannot always be sure that the asylum life is the only factor in the development of such cases. The short interval between the departure of the patient from his home, and his admission within the gates of his prison, may have served to fix the old or produce entirely new symptoms, which the asylum officers cannot but look upon and treat as indicating the patient's ordinary condition. We may doubt the competence of the police, who have much to do with the transmission of lunatics, to act as their custodians; and when the lunatic's friends or neighbours undertake his removal, their attentions are quite as likely to aggravate his derangement. If inquiry were made into the condition of lunatics before their removal from home and on their arrival at the asylum, it would in many cases disclose differences indicating evil results from injudicious management during their transmission. Injurious handling could be obviated by charging the superintendents of asylums, or inspectors of the insane, with the duty of sending a trained attendant to take charge of a patient, on the receipt of notice from the police or those committing him to the asylum. A suggestion may also in the meantime be made, that the St John Ambulance Association should include first attention to the insane in their course of training.

If we may venture to assume that the main object of placing the insane under restraint in asylums is for purposes of treatment, with a view to the cure or alleviation of their mental disease, it will follow that anything tending to impede the medical officers, in their attempts to bring about the most favourable result, is necessarily prejudicial and out of place. Such an obstacle to efficient treatment exists in the details of general management, which occupy so much of the time and attention of the superintendent under the existing system. These make it difficult or impossible for him to keep *au courant* with the progress of medical knowledge, even in his own specialty; and, as a consequence, his patients cannot obtain the attention and treatment they ought by rights to receive. The junior medical officers are bound to follow the example of the superintendent, in order to prepare themselves to occupy similar positions in the future. If, therefore, the medical superintendent were relieved of the cares and trouble of non-professional management of the asylum—which is quite out of his province as a medical man—he would be able to keep abreast of the times in his knowledge of mental diseases, and with assistants working under him, to give due attention to the

study and treatment of each and all of the patients under his charge. Relieving the medical superintendent of the general management, however, does not necessarily imply the appointment of a lay superintendent on an equal footing with the former. With the medical head of the asylum giving his whole attention to the patients, a lay manager or director would neither be competent to take up the work done at present by the medical superintendent, nor would the two heads, if on an equal footing of authority work well together, for reasons already indicated in a former article. The qualifications necessary for the general management of the asylums,—in the wider sense of the words, as at present understood—include, as we have also seen, a preponderance of those held only by medical men; so that with the medical superintendent confining himself to medical duties, and divided authority being objectionable, we must resort to the Board of Commissioners in Lunacy itself, which, after all, is alone competent to manage the many-sided business of lunatic asylums. Such a Board as I have advocated—consisting of five or seven members, with a preponderance of Medical Commissioners—would possess full authority, and it would be competent, while the efficient supervision of the insane and the management of their affairs would be sufficient to keep all the members fully occupied. The superintendent would still be supreme in his own asylum, the whole of the appliances of which would be unreservedly at his disposal for all purposes connected with the discipline and treatment required by his patients. His orders would be carried out as now by the different officers under him, some of whom, however, would be in a special sense under the supervision and direction of the Commissioners themselves. The steward, farm bailiff, gardener, &c., would supply this or arrange that, to meet the needs of the patients, as the superintendent might direct; and his requisitions would in all cases be carried out as far as the resources of the establishment permitted, anything beyond the ordinary requirements being referred to the Board or to individual Commissioners. The superintendent would be responsible to the Board for the nature and extent of his requisitions, while the lay officers would be answerable for the way in which their duties were performed.

The Board of Commissioners would thus undertake the "lay" management, and allow the medical officers to apply themselves as professional specialists to the study and treatment of diseases of the mind. It is clear that a board of three members would never suffice for the efficient management in addition to the duties of supervision. Their visits would necessarily be much more fre-

quent than is the case with the present English Lunacy Board; and that is exactly what is urgently required in the interest of the inmates. These reasons would be sufficient for the creation of a Lunacy Board of 7 members, of whom 3 or 4 should be medical; but there are weighty reasons for thinking that, failing the appointment of a large board, it would be preferable to let matters stand as they are, as regards the duties of medical superintendents of asylums. It was during times of political trouble in Victoria that the appointment of lay officials was mooted and the object of the changes then meditated was not specially the benefit of the insane. We cannot expect to escape a recurrence of such troublous times, and it is evident that with a small board of 8, one only of whom is a medical man—perhaps of weak resisting power—political influences could easily be brought to bear with effect on the members of the board, so that the whole management might be subjected to the intrigues of the professional politician, and medical interests, alike of patients and professional staff, made subordinate. The presence of three or four medical men in the board of control would be the best guarantee that the interests of the insane would be safe from such sinister influences.

For appointments in the lunacy department of the public service, evidence should be required, in addition to the license to practise, of special knowledge of the anatomy and physiology of the nervous system and of mental diseases in their theoretical and practical aspects, not omitting the preliminary subject of psychology. Candidates should have passed two or three years in general practice, with the object of widening the observing faculty, and cultivating common-sense views of the treatment of disease, which can only be gained by experience, as a corrective of undue leaning towards theory. The degree of M.D. should certainly be sufficient qualification for such appointments, but it would be absurd to regulate its examinations solely by the requirements of so small a number of graduates as would follow this specialty. The degree licensing to practise should cover sufficient ground to qualify ordinary practitioners to recognise mental diseases or symptoms as they are found in general practice, and to treat them on general principles; and this would form a basis on which to begin the additional studies necessary to qualify for the responsible care of the insane.

The objections urged against the addition of psychological medicine to the curriculum must be one and all dismissed as untenable in face of the fact that mental diseases are most curable in their earliest stages, namely, at the time when they first come under the notice of members of the profes-

sion. It may be allowed that persons showing signs of insanity should be removed at once to an asylum, but though this course is generally the best under present circumstances, it can only be proper at a stage when the need for asylum treatment has already arisen. Is this stage, however, the earliest? Is insanity always produced, as it were, ready made, without having passed through previous phases? If we do not know much of the first beginnings of insanity, that is no proof that they do not exist, and our ignorance does not excuse us from making no attempt to investigate the earliest and premonitory symptoms. For filling up the hiatus in our knowledge of the mental symptoms of ordinary disease and of the earlier and premonitory symptoms of diseases of the mind, at present only known in their fully developed state, reliance must be placed on those working in the field where the facts bearing on the subject are to be found, namely, in general practice. As a matter of fact, in ordinary practice patients do often make mention and complain of mental symptoms which give way to simple treatment, even though that treatment may have been directed against concomitant symptoms of an entirely different character. If it is the duty of medical men to recognise and treat symptoms premonitory of the fully developed disease, students ought to be taught such facts as bear on the subject, and to have their attention directed to the necessity for observation of mental symptoms as they occur in practice.

Though a modicum of information on the best known mental diseases might be imparted in the general course on medicine, it would be quite inadequate, and besides, in that course the mental symptoms of ordinary disease could hardly be taught, seeing that they are for the most part unknown. Future practitioners, however, if they are to avail themselves of their opportunities for observing those symptoms, and, it may be added, of instructing their former teachers, must be grounded in what is known of the fully developed diseases and in the methods of studying and treating them: hence the necessity for adding psychological medicine and the corresponding clinical instruction in hospitals for the insane to the curriculum. The inherent difficulty of the study, and its comparatively undeveloped state, combine to show the propriety of its being entered on only after training in the other subjects is completed, and perhaps even after the examinations in all other subjects have been successfully passed. Examination for the license to practise, however, should not include more than is likely to be useful in ordinary practice, including diagnosis, prognosis and ordinary treatment; while for the M.D. degree the whole field of instruction

in the systematic course, in laboratories, and hospitals for the insane, should be covered in the examinations.

The ordinary duties of examining and treating patients will be well enough understood by every student who has passed through the practical part of the medical curriculum, but in asylums special circumstances are encountered which make it necessary that some experience of asylum practice should be gained before the medical tyro can be placed in responsible charge. In Government institutions, where the work of those employed is so apt to degenerate into mechanical routine, it is necessary that that routine should be accurately defined, and its performance strictly exacted, so that none of the essentials should run the risk of being overlooked. At the same time a high standard as regards accuracy and completeness should be kept up without restricting the work of the officers to mere utilitarian ends, for it is only right that Government institutions should be carried on in such a liberal and far-seeing spirit, that the records of work done shall be complete and available for reference at any future time, and for any purpose for which they might be found useful. This is peculiarly the case in the lunatic asylums in Australia, where the conditions of life are, or have been, somewhat different from those of European countries, and where there is such a mixture of almost all the nationalities, creeds, and degrees of civilization on the face of the globe. For the ordinary purposes of the statistician, accurate and complete records of the simplest and commonest facts are invaluable, and it is well to recognise this circumstance before the possibility of making up the records has gone for ever. Every fact that can be recognised, if well recorded over some space of time, may be made use of, and turned to account in the future by statisticians in ways that we probably have now little conception of, and with results of importance to the world at large. This applies not only to purely medical statistics, but to those relating to all cognate branches of science; and in the asylums of Australia it is especially so in reference to ethnology, from the great variety of races presented for observation there. Such a mixture is offered to students of ethnology nowhere else, and the number of different races and tribes will probably, in a short time, be increased by the addition of natives of New Guinea and of the islands of the Pacific now being opened up to commerce. A thorough examination of such patients leisurely undertaken in an asylum, may give results second only in value to those obtained by the original investigators of the race or tribe to which they belong. Not only so, but cerebral structure, and perhaps its lesions may be found to be of a simpler type in

the more lowly organised brains, or in those of pure as distinguished from mixed races, and, therefore, more easily analysed. In the brains of savage or semi-savage peoples the same lesions as those found in civilised races may produce mental symptoms very dissimilar in the two cases; and the influence, in the production of the symptoms, of modes of life, as distinguished from organic changes of structure, might possibly be detected. In fact, the study of comparative medical psychology is certain to produce new facts and to lead to new conceptions of the nature and causation of many diseases of the mind.

To complete the record of each case under observation in hospitals for the insane, an account of the *post mortem* examination is necessary. Whatever weight may be assigned to the necessity for independent medical evidence as to the cause of death and the condition of the bodies of the insane, on all of which inquests are held, it is certain that no method could be better devised than that now in force in Victoria, for stifling the interest of the asylum officers in the patients under their charge. To a medical man who has given time and pains to the diagnosis and treatment of his cases, the *post mortem* is the crowning interest of the whole, and nothing can be more irksome to him to stand by and see every organ of the body cut to pieces with the object of discovering any sign of maltreatment as bearing on the cause of death. It would surely satisfy the demands of the law if the outside practitioner appointed to make the *P.M.* were the onlooker at autopsies made by the physician who had had charge of the case. The latter is entitled to be the actor-in-chief, examinations for asylum purposes being necessarily more minute and requiring more care than the great majority of those made for medico-legal purposes. He alone knows the *ante mortem* conditions which must be kept in mind at the autopsy, if it is to be so completely and carefully made as to throw the fullest amount of light on the symptoms observed during life. The outside pathologist could direct the asylum officer to display this or that part without the latter spoiling the subject for the more minute purposes of his special interest in the examination. The former would be in much the same position as an official medical visitor. In the country districts the duty could be performed by the proposed inspector in lunacy, and in the metropolis by a Government pathologist—an official for the appointment of whom other medico-legal duties would afford sufficient justification. The *post mortem* examinations in this way could be placed under official inspection as part of the general scheme of supervision by the Board of Commissioners, Inspectors and official Visitors.

In asylums for chronic and incurable cases, though the medical staff need not be large, yet close attention should be given to the *post mortem* appearances, for such records as they supply would be the means of throwing much light on the clinical history of cases that had passed through the other asylums.

Inquiry into the causes of mental disease is of great importance for the purposes of the statistician, as leading towards the attainment of preventive measures. In such inquiries asylum physicians have every right to expect general practitioners to give all the assistance in their power; and it would be one of the duties of inspectors or official examiners in lunacy, if such were appointed, to collect information bearing on the subject from the patient's friends, his medical attendant or the police. These particulars ought as far as possible, to be ascertained before treatment is begun, and many other facts bearing on the history of each case could be obtained in the same way and from the same sources. The mental habits and general character of the patient, not merely as changed since the commencement of his derangement, but during his previous ordinary health, and how these traits stand with reference to those of his parents or other relatives, would be necessary for an exact appreciation of the symptoms actually observed in the hospital. Symptoms at first sight supposed to be indicative of morbid action, might be found to be due to, or modified by habit or idiosyncrasy. Inquiries of this description would be suggestive of particular means of treatment, and would be essential to thoroughness, but they presuppose an organised system which would allow such attention to be given to each patient.

These remarks on the utilisation of the material for research available in lunatic asylums, seem à propos of the action not long since taken by the Victorian Government in passing into law an Anti-vivisection Statute. Having by its means practically prohibited one important means of research, the Government thereby makes itself responsible for its endowment. If it meddles in one way with investigators by regulating in an oppressive manner what it considers liable to abuse, it is bound to take research under its protection when it can be shown to deserve encouragement. An opportunity of encouraging and endowing research is ready to hand in the Government lunatic asylums, by means imperfectly indicated above. Any steps in this direction would be appropriately taken in connection with the University, which we must suppose is, *par excellence*, the institution officially recognised as including in its aims the advancement of knowledge for its own sake. If we take into consideration the great inconvenience

and loss to the community through disease of the mind, and the importance to future generations of such means of treating and preventing the development of those diseases as will help to wear out the tendency to hereditary transmission of the taint, it will not appear inappropriate or impolitic if—instead of the shameful neglect that people appear to think is of necessity the portion of those who have lost their reason—the ruling powers should treat the study of diseases of the mind as an object of such national importance as would be fittingly recognised by special endowment in connection with the hospitals for the insane.

The connection that ought to exist between the University and the hospitals for the insane is essentially the same as that between it and the general hospitals; and in each case the advantages are mutual. In Melbourne the Yarra Bend Asylum is as conveniently situated for this relationship as any site with sufficient land attached could be, and the perfect seclusion and healthiness of the locality render it peculiarly fit for the reception of the many recent cases of insanity supplied from the metropolitan district. The proposal to sell this site and the adjoining Kew Asylum reserve is therefore ill-advised and detrimental to the interests alike of the insane and of the medical school. The motive for this proposed spoliation—the conversion of the land into money, and the banishment of the insane to a cheaper site in the country, further out of mind—can only be characterised as iniquitous. At the present day the impossibility in London of finding space for the proper treatment of lunatics is felt to be a serious obstacle to the improvement of their condition, and it would be a short-sighted act for any other city to wilfully place itself in a similar position.

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THE *Deutsche Kolonialzeitung* published in Berlin, on occasion of the 59th Congress of German scientists and physicians, held in Berlin during the month of September last, has issued a special number on "*Medical Geography, Climatology and Tropical Hygiene*." In twenty-five original articles nearly all the tropical and subtropical countries of the world are dealt with. Particular attention has been paid to the question of acclimatisation in the (by Germany) newly acquired territory of Central Africa. Australia is represented only by two articles, one by Dr. Schwarzbach, of Sydney, dealing with the sanitary conditions of New South Wales, and the other by Dr. Renner, of South Australia, who dwells on the climatical influence on diseases in the colony in which he lives. In the same issue we find a translation of the article by the Rev. W. G. Lawes, of Port Moresby, on the Customs among the Natives of New Guinea in sickness and childbirth, published in the June number of the *A. M. Gazette*.

REVIEW.

Paryses: Cerebral, Bulbar, and Spinal—A Manual of Diagnosis for Students and Practitioners. By H. CHARLTON BASTIAN, M.A., M.D., F.R.S., &c., &c. London: H. K. Lewis, 1886.

DR. CHARLTON BASTIAN, who wrote the article on paralysis in Reynolds' System of Medicine and the articles on paralysis, diseases of the nervous system, diseases of the brain, and diseases of the spinal cord, in Quain's Dictionary, and who—as physician to the National Hospital for the paralysed and epileptic—has exceptional opportunities of studying paralysis in its various forms, has dealt in this volume with the diagnosis of all the forms of paralysis, including those of the different cranial nerves, in a complete and masterly manner. It extends to 657 pages, and is enriched with numerous illustrations, but is distinctly a manual of diagnosis only, the question of treatment not being entered on. It exhibits at its fullest the strength and the weakness of modern English medicine, especially in regard to diseases of the nervous system. Dr. Hughlings Jackson, Dr. Gowers, and Dr. Bastian, to mention three only out of a host of workers, have done great things in the direction of diagnosis, but have but little advanced treatment. Dr. Bastian has no doubt had in mind the old adage that "when a correct diagnosis is formed the patient is half cured," but at the same time one cannot help feeling a regret that his exceptional advantages as regards the treatment of nervous diseases have not been made more available for the information of his professional brethren. It may be that Dr. Bastian has but little to tell, or it may be—as we would fain hope—that he is digesting his material with a view of giving it to the profession in a future volume.

The Author's present endeavour, as we gather from a brief preface "is to facilitate diagnosis—to explain and gather up the essential points to be borne in mind by the student or practitioner when he is called upon to decide as to the nature of, and give a prognosis concerning, any case of paralysis that may come before him."

The volume is divided into four parts, in which paryses of encephalic and of bulbar origin, paryses due to lesions of cranial nerves, and paryses of spinal origin are respectively discussed. Where all is so full and complete it is difficult, and to some extent tedious, to call attention to special chapters, but in the 1st part the chapters on pathological diagnosis and "the clinical indications favouring the existence of this or that causative condition," and dealing at length with

the primary and secondary comas, are interesting and of high practical value. Part 2, dealing with paryses of bulbar origin, occupies only some twenty-five pages, perhaps the best and fullest guide to these in the language; and Part 3. in which paryses due to lesions of the cranial nerves are described contains much that is new—the different types due to special nerves being set forth in exhaust detail.

In Part 4, after some preliminary data, diagnosis is first dealt with, and the indications favouring the diagnosis of disease this or that region of the spinal cord are set forth and the value of the skin and tendon reflexes shown. The pathological diagnosis is then entered on, and the extrinsic and intrinsic causes fully considered, as well as the relative rapidity of action of the several conditions which cause spinal paralysis, and finally the combined regional pathological diagnosis of the various specific diseases are detailed under twenty-four headings which include all the varieties of spinal paralysis from those due to fractures and dislocations to insular and disseminated sclerosis and Freudreich's disease.

The volume includes a full and excellent index, will be of the utmost value to all engaged in the special study of diseases of the nervous system, and afford material assistance in many cases to the "puzzled practitioner."

THE MONTH.

NEW SOUTH WALES.

THE Governor in Council, on the recommendation of the Board of Health, has declared the following diseases to be infectious for the purposes of the Diseases Registration Act:

A.—Infectious benign—Cholera, Enteric Fever, Small Pox, Scarlet Fever, Diphtheria, Measles, Syphilis, Rickettsia.—Arboviral—Cancer, Pleuro-Pneumonia, Splenic Fever, Enteritis, Ulcer—infestation, eruptive, or warts of.

The sum of £8000 has been placed upon the estimate for the erection of a medical laboratory at the Sydney University. The building will consist of an isolated tower, rooms for spectroscopic examinations, for photographic purposes, for chemical works, for instruments, for stores, for workshops, and for students' laboratories, private and public.

The Protestant Asylum School at Parramatta is to be made into a hospital for chronic and incurable diseases.

A MAN who had aspergited his penis by means of the solid jet of a carpenter's plane and a brush was taken to the Balmain Cottage Hospital on Saturday, November 4th. The dead was pronounced about 11 o'clock on November 5, and it was not found out until

dinner time of the following day. It is supposed that it was done during a fit of insanity.

AT the Newcastle District Court, on December 1, Dr. Wiston Baker sued James Smallcambe for £38 17s. for medicine and medical attendance. It appeared that defendant was a member of a medical club, and plaintiff, as its doctor, had attended him and his wife and family at 6d. per week. He attended a woman, who passed as defendant's wife, for 12 months. Subsequently, plaintiff learned that she was not Smallcambe's wife, therefore, he charged defendant with medicine and attendance. The defence was that the woman was ill only three weeks, and had only been given five or six bottles of medicine. A verdict was given for plaintiff for £30 and costs.

DR. G. CUSCADER, late of Port Wakefield, S.A., has succeeded to Dr. J. F. Anderson's practice at Urania, in a pastoral and agricultural district, 381 miles S.W. of Sydney.

DR. L. DRIUITT, a recent arrival, has settled at Cooma, in a pastoral, agricultural, and mining district, 257 miles S.W. of Sydney.

DR. JOS. ENGLISH has commenced practice at Gundagai, in an agricultural district, 165 miles S.W. of Sydney.

DR. A. FREELAND has settled at Gundagai, on the Murrumbidgee river, in a pastoral and agricultural district, 289 miles S. of Sydney, he having been elected Medical Officer to the local hospital, in the place of Dr. Murphy, who has removed to Hillston, on the Lachlan river.

DR. E. E. GRIFFITHS has returned from his trip to England, and resumed practice at Blayney.

DR. P. SYDNEY JONES, of Sydney, has been appointed a member of the Medical Board of N. S. Wales, vice Dr. Mackenzie, deceased.

DR. H. K. KING, formerly of Moruya, has commenced practice at Nowra, in the Shoalhaven district.

GEORGE HENRY KNIGHT, L.S.A., Lond., 1880, of Leichhardt, near Sydney, in the employ of the Australian Widows' Fund Life Assurance Society, whilst riding along the Kangaloon and Bowral roads fell from his horse twice, sustaining severe injuries. He was taken in vehicle to Bowral, but expired before reaching that place. An inquest was held, when the verdict was to the effect that deceased came by his death by congestion of the brain, accelerated by excessive use of alcohol.

DR. M. J. LYDEN has commenced practice at 307 Cleveland-street, Redfern, a suburb adjoining Sydney.

DR. H. S. LYONS, late Deputy Medical Superintendent of the Lunatic Asylum, Beechworth, Vic., has settled at Albury.

DR. W. J. MOUNTAIN, late of Border Town, S. A., has settled at Walbundrie, in a pastoral district, 418 miles S.W. of Sydney.

DR. M. D. MURPHY, late of Gundagai, has removed to Hillston, on the Lachlan river, in a pastoral district 435 miles W. of Sydney.

DR. K. L. O'DOHERTY has been elected Honorary Surgeon to St. Vincent's Hospital, Sydney.

DR. ERIC SINCLAIR, Medical Superintendent of the Gladesville Hospital for the Insane, has returned to the colony by the Orient R.M.S. "Lusitania."

DR. WM. STUART, a recent arrival, has settled at Minmi, near Newcastle.

DR. E. STANLEY TRESIDDER, formerly of Coonamble, has commenced practice at Glen Innes, in an agricultural, pastoral, and mining district, 400 miles N.W. of Sydney.

DR. C. G. THORP, of Blayney, has removed to Mudgee, where he has commenced practice in conjunction with Dr. C. Swanston.

DR. J. D. WATT, late Acting Resident Medical Officer of the Gladesville Hospital for the Insane, has commenced practice at Picton, 53 miles S.W. of Sydney.

We have been requested to state that "Liebreich's Lanoline," the new basis for ointments, can be obtained at Senior's Pharmacy, 246 George street, Sydney.

NEW ZEALAND.

The Annual Meeting of the St. John Ambulance Association at Christchurch, was held on November 18; the annual report presented was of a very satisfactory nature.

THE Senate of the University of Cambridge recommend that the University of New Zealand should be affiliated with the Cambridge University.

DR. HY. ANGUS has settled at Waikouaiti, in a fine agricultural district, 32 miles N. of Dunedin.

DR. K. G. T. BRANTING has commenced practice at Woodville, in an agricultural district, 100 miles S.W. of Napier.

DR. H. D. DAVENPORT has commenced practice at Foxton, at the mouth of the Manawatu river, 71 miles N.E. of Wellington.

QUEENSLAND.

IN the Supreme Court, on November 12, an action was brought by Dr. Ridgley, of Townsville, against the proprietor of the Townsville *Northern Standard* and *Echo* newspapers for £6000 damages, for an alleged libel contained in the issue of December 11 of the *Standard*, and of December 12 of the *Echo*, comprising severe strictures on the plaintiff's conduct as Government health-officer, in boarding the steamer Dorunda when cholera was on board, and immediately coming ashore. The defence declared that the articles bore no defamatory meaning against any individual, but commented on the health-officer as a public servant. The jury returned a verdict for defendants, for whom judgment was entered, with costs.

IN the Brisbane Police Court, on November 17, Dr. Ridgley, of Townsville, summoned Mr. Macartney, a clerk in Mr. Thynne's (solicitor) office, for assault by horse-whipping. Defendant had waylaid the plaintiff and slashed him across the legs with a riding-whip, for alleged aspersions upon the character of defendant's late brother. The Bench fined Macartney £1 and costs.

WE are informed that the amount of spirits consumed in the Aramac hospital for the last twelve months, amounted to only one gallon and a half; there was no wine or ale used at all, and, doubtless, there is no other hospital in Queensland that has used such a small quantity of spirits in proportion to the patients admitted. The number of indoor-patients treated from January, 1, 1886, to November 22, was 89, of whom only six died, viz.—two aborigines, one Chinaman, and three Europeans.

DR. M. MATHESON, late of Aramac, has left for America, for the purpose of going through a six months' course of study at the New York Polyclinic, a school of Clinical Medicine and Surgery to which only

practitioners are admitted. Dr. Matheson intends to return to Australia, via London, in August next.

DR. H. C. BRANNIGAN has settled at Aramac, the centre of a fine pastoral district, 750 miles N.W. of Brisbane; Dr. Brannigan has been appointed Medical Officer to the local hospital.

DR. J. E. ST. G. QUEELY, of Ingham, has removed to Cairns, a seaport 1020 miles N.W. of Brisbane.

SOUTH AUSTRALIA.

AT a meeting of the Council of the University of Adelaide, held on November 19, the following appointments were made to the Lectureships in the School of Medicine:—Dr. Thomas and Dr. Verco, joint Lecturers on the Principles and Practice of Medicine and Therapeutics; Dr. Gardner, Lecturer on the Principles and Practice of Surgery; Dr. Way, Lecturer on Obstetrics and Diseases Peculiar to Women; Dr. Lendon, Lecturer on Forensic Medicine; Dr. Giles, Lecturer on Aural Surgery; and Dr. Symon, Lecturer on Ophthalmic Surgery. Resolved, that Dr. Paterson be invited to accept the Lectureship on Lunacy; and that Dr. Watson be invited to accept the Lectureship on Operative Surgery, the Lectureship on Surgical Anatomy, and the Lectureship in Pathological Anatomy. The Council also appointed the present staff of the Honorary Physicians and Honorary Surgeons of the Adelaide Hospital to the three Lectureships on Clinical Medicine and to the three Lectureships on Clinical Surgery for a term of five years from the date of their appointment, subject to the condition that the office should cease on any of them ceasing to be on the staff of the Hospital. The following are the gentlemen appointed:—Joseph Cooke Verco, M.D., Edward Willis Way, M.B., W. T. Hayward, M.R.C.S., Lecturers on Clinical Medicine; William Gardner, M.D., Oscar Görger, M.D., Edward Charles Stirling, M.D., F.R.O.S., Lecturers on Clinical Surgery.

THE Council of the University of Adelaide have admitted the following gentlemen *ad eundem gradum*:—Robert Stewart, M.D., University of Melbourne; W. Anstey Giles, M.B., University of Edinburgh; J. H. Suffield Finnis, M.B., University of Edinburgh.

DR. B. KORFF, late of Norwood, has removed to Silverton, and Dr. E. F. Seabrook, late of College Town (Adelaide), to Broken Hill, near Silverton (N.S.W.), the centre of the celebrated silver mines in Central Australia.

VICTORIA.

AT the meeting of the Central Board of Health, held on November 26, a proposition made to the Government by Dr. Turner that a Royal commission should be appointed to enquire into the causes of typhoid fever and measures for its prevention was considered, but the board unanimously decided that it could not recommend the Government to appoint such a commission. It was determined, however, to explain to the Government that the amending health bill, which the board had recommended many months ago for introduction in Parliament, would give power to conduct all inquiries necessary to be held in regard to outbreaks of typhoid or other diseases.

IN last month's issue we stated that Dr. M. Perceval, of St. Kilda, had been elected Resident Surgeon of the Clunes district hospital. The announcement having been brought under the notice of the Central Board of Health, the secretary sent a letter to the committee of the Clunes Hospital informing them that Dr. Perceval

was not eligible for the appointment, being unregistered. Section 13 of the Medical Practitioners' Act prohibits any unregistered practitioner from holding an appointment as physician, surgeon, or medical officer in any hospital, and certificates signed by an unregistered practitioner are declared by the same section to be illegal. Dr. Perceval has since registered his diplomas with the Medical Board of Victoria.

A MEETING of trained nurses was held on December 2nd, at the Melbourne Town Hall, to consider a proposal for establishing a nurses' home and registry in some central position in Melbourne. It was explained that many of the ladies who become nurses have no permanent homes of their own near Melbourne, and are living in boardinghouses in different suburbs. The idea of the promoters of the association was that if all nurses when out of engagements lived together, or, if having homes of their own near town, registered themselves as members of the association, the arrangement would mutually benefit themselves and members of the medical profession requiring their services. It was proposed that Miss Hawthorne should be president of the association, to be called the Victoria Trained Nurses' Association, and that Mrs. Spillman should be superintendent of the home, for which a building in George-street, East Melbourne, was suggested as being most suitable. It was further proposed that any profits in connection with the home should be devoted to the establishment of a nurses' sick fund. The project was generally approved, and the preliminary steps were taken for carrying it into effect.

A MEETING of the University Council was held on Saturday afternoon, December 4, being the last day of the October term, for the purpose of conferring degrees. The following is a list of the candidates upon whom medical degrees were conferred:—

Bachelors of Medicine—Alfred Victor Millard Anderson, William Robert Boyd, John Henry Carney, Henry O'Brien Deck, Carl Peter Wilhelm Dyring, George James Archibald Billing Halford, William Kilpatrick, Robert James Loosli, John Frederick William Manson, William Lowell Mullin, Albert Alexander Parry, George Campbell Rennie, Edward Emerson Rosenblum, Thomas Francis Ryan, James Service Thomson, Arthur Mackenzie Wilkinson.

Ad Eundem Gradum: Charles Yaldwyn Shuter (University of Durham).

Doctor of Medicine—Ad Eundem Gradum: Samuel Connor (Royal University, Ireland). Patrick Doyle (Queen's University, Ireland). Edward Graham Ochiltree (Glasgow University).

Bachelor of Surgery—Robert James Loosli, John Frederick William Manson.

Ad Eundem Gradum: Samuel Connor (Royal University, Ireland).

MRS. ELIZABETH TAYLOR was sentenced to two years, with hard labor, at the Central Criminal Court, on November 25, for the manslaughter of the girl Warburton, who died from the effects of an illegal operation.

IN the Supreme Court, on November 25, a rule was made absolute for the sequestration of the estate of Dr. S. W. Brierley, late Deputy Medical Superintendent of the Beechworth Lunatic Asylum.

DR. F. D. BIRD has resigned the position of Demonstrator of Anatomy at the Melbourne University.

DR. W. H. CAMPBELL, the oldest practitioner of Melbourne, has removed from 34 Russell-street to 92 Hotham-street, East Melbourne.

MR. EDWARD HALL, M.R.C.S.E.; 1842, late of Toorak, near Melbourne, is dead.

DR. PETER LYNCH, late of Smythesdale, has commenced practice at Warwick House, corner of Drummond and Grattan streets, Carlton, a suburban city adjoining Melbourne.

DR. W. N. NEVILLE, a new arrival, has commenced practice at Macarthur, in a pastoral and agricultural district, 244 miles W. of Melbourne.

DR. G. A. WALPOLE has succeeded to the practice of Dr. T. D. Atkins, at Rosedale, in an agricultural and pastoral district, 111 miles E. of Melbourne.

CHARLES ERSKINE WYER, L. et L., Mid. R.C.P. et R.C.S. Edin., 1876, F.R.C.S. Edin., 1881, late honorary Medical Officer of the Geelong Infirmary, died at Peebles, Scotland, on September 30th, at the early age of 32.

WESTERN AUSTRALIA.

DR. GEO. BOYES, a recent arrival, has settled at Greenough, the centre of an agricultural district, 273 miles N. of Perth.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

d'Engesqueville, Maurice Louis Antoine Cotton, M.D., Paris, 1885.

Jackson, George Cecil, L.R.C.S. Irel., 1873.

Kerr, John, M.B. Glas., 1888; M.S. Glas., 1888.

Blaxland, Ernest Gregory, M.R.C.S. Eng., 1886; L.R.C.P. Lond., 1886.

Cusack, George, L.R.C.P. Edin., 1880; L.R.C.S. Edin., 1880.

Paton, Robert Thomson, L.R.C.P. et S. Edin., 1886.

Bennie, John Taylor, M.D., Michigan College of Medicine, U.S.A., 1884.

Williams, Ezra Harlurt, M.D., Univ., Trin. Coll., Toronto, 1884; L.R.C.P. Lond., 1884; C.M. Univ., Trin. Coll., Toronto, 1884; M.C.P.S. Ont., 1884.

Jefferis, James Eddington, M.B. et M.S., Univ., Aberd., 1886; M.R.C.S. Eng., 1888.

Mahony, Edward Eugene Augustus, L.S.A. Lond., 1883; M.R.C.S. Eng., 1883.

QUEENSLAND.

Edgeland, Samuel Henry, M.R.C.S. Eng., 1877.

Nutting, Philip Henry, L.R.C.P. Lond.; M.R.C.S. Eng., 1885; L.S.A. Lond., 1884.

Rooney, James, L. et L. Mid. K.Q.C.P. Irel., 1874; L.R.C.S. Irel., 1878.

VICTORIA.

Broom, Charles, M.R.C.S. Eng., 1885; L.S.A. Lond., 1885.

Nevill, William Napper, M.B. et Ch.B. Dubl., 1886.

Johnson, John James, M.B. et Ch.M. Edin., 1886.

Gaunson, Francis Henry, L. et L. Mid. R.C.P. et R.C.S. Edin., 1886; L.F.P.S. Glas., 1886.

Penny, John Alexander Cairns, L.R.C.S. Irel., 1881; L. et L. Mid. K.Q.C.P. Irel., 1881.

Additional Qualification registered:—

Fletcher, Arthur Augustus, M.B.C.S. Eng., 1886.

WESTERN AUSTRALIA.

Boyes, George, M.B. et Ch.M. Aberd., 1881.

MEDICAL APPOINTMENTS.

Aitken, William Blair, M.B. et Ch.M. Glas., M.R.C.S. E., appointed Junior House Surgeon at the Adelaide Hospital, S.A.

Angus, Henry, M.B. et Ch.M. Aberd., to be Public Vaccinator for the district of Waikouaiti, and also an additional Public Vaccinator for the district of Palmerston South, N.Z.

Boyes, George, M.B. et Ch.M. Aberd., to be District Medical Officer and Public Vaccinator for the Greenough district, W.A.

Branting, Karl Gustaf Teodor, Surgeon, to be Public Vaccinator for the districts of Woodville and Danevirke, N.Z.

Davenport, Harold Devereux, L.R.C.S.I., to be an additional Public Vaccinator for the district of Foxton, N.Z.

Dobbin, William Sinclair, M.B. et Ch.B. Dubl., F.R.C.S. Irel., to be Health Officer for shire of Ballan, Vic.

Dunn, Walter, M.R.C.S.E., to be Public Vaccinator for district of Mount Benger, N.Z.

Durham, John Charles Crozier, L.R.C.S.I., to be a Surgeon in the Victorian Militia.

McBrearty, James, L.F.P.S. Glas., to be an additional Public Vaccinator for the district of Kumara, N.Z.

Plewa, Edward William, L.S.A. Lond., to be Health Officer for the East Riding of the shire of Ballan, Vic.

Reid, George More, M.D. Edin., M.R.C.S.E., L.R.C.P. Lond., to be Public Vaccinator at Castlemaine, Vic., vice Dr. M. A. Muirhead, resigned.

Springthorpe, John William, M.D., to be Public Vaccinator at East Melbourne, vice Dr. R. Peel, resigned.

Wall, Max, M.D., to be Public Vaccinator at Ondit, Vic.

Wilkie, David William Balfour, M.B. Melb., M.R.C.S.E., to be Public Vaccinator for Dean Marsh, Inverleigh and Lorne, Vic.

PUBLICATIONS RECEIVED.

The Principles that underlie the Art of Teaching: Six lectures, delivered at the Technical College, Sydney. By W. Wilkins, ex-Under-Secretary for Public Instruction. Sydney: Government Printer, 1886.

The Mechanism of Indirect Fractures of the Skull.—By Charles W. Dulles, M.D. Philadelphia: P. Blakiston, Son and Co., 1886.

The Medical Man's Handy Book.—By Wm. Shepperson. London: J. and A. Churchill.

Ueber Thermostaten, Thermoregulatorien, und das Constanthalten von Temperaturen.—By Dr. Hermann Rohrbeck. Berlin: Eugen Grosser, 1886.

La Amigdalitis Simple y el Bicarbonato Sodaico.—By D. Rosalino Rovira y Oliver. Barcelona: J. Balmas Planas, 1886.

Dr. JOHN REID, of Port Germein, S.A., the discoverer of Drumine, the new Australian local anaesthetic, described by him in the October issue of the *A.M.G.*, informs us that he now prepares this alkaloid very cheaply, thus:—Whole plant macerated for 8 days in dilute hydrochloric acid or boiled for one or two hours in dilute acid. It is then filtered, and the liquid filtrate neutralised with soda bicarbonate and stirred for some time until drumine has been precipitated; this is filtered, and the colouring matter, extractives, &c., washed away with distilled water until drumine alone remains on the filter. It may be dissolved in spirit or in acid and again evaporated to obtain neutral salt.

REPORTED MORTALITY FOR THE MONTH OF OCTOBER, 1886.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.
N. S. WALES.												
Sydney	125,000	332	170	78	...	2	1	2	...	10	18	10
Suburbs	175,000	798	297	167	...	5	2	6	6	22	17	14
NEW ZEALAND.												
Auckland	38,161	93	23	11	...	...	1	1	..	2	2	2
Christchurch	15,265	37	17	4	...	...	2	2	1	3	3	2
Dunedin	23,243	46	22	6	...	2	2	2	2	3	3	1
Wellington	25,945	71	23	9	2	...	...	...	1	3	3	2
QUEENSLAND.												
Brisbane	32,571	112	39	34	{	...	1	...	...	14	5	6
Suburbs	19,112	70	42	17	...	...	3	3	...	1	7	1
SOUTH AUSTRALIA.....	316,920	912	255	108	1	1	13	6	...	6	22	19
Adelaide	58,000	144	53	17	...	...	3	...	...	1	7	5
TASMANIA.												
Hobart	29,578	89	27	14	...	2	5	1	...	3	3	3
Launceston	18,674	72	19	9	...	1	2	1	...	5	2	2
Hospitals, Asylums, Gaols, &c. .	1,284	...	34	2	...	...	...	...	...	...	...	...
Country Districts.....	86,069	268	64	...	...	...	1	...	...	1	...	...
VICTORIA.												
Melbourne	69,774	183	92	{ 157	4	...	9	10	6	18	56	81
Suburbs	275,606	872	398	...	...	...	...	...	...	...	...	20
												46

METEOROLOGICAL OBSERVATIONS FOR OCTOBER, 1886.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Inches		Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	79·3	58·4	39·5	29·821	...	...	...	75	..
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	132	68·5	56·7	44·	...	8·420	17	9	60	N.E.
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	158	92·	71·9	49·	29·954	2·33	12	74	..	..
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	138	77·2	51·0	32·8	...	2·222	15	68	..	..
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	126	75·	51·4	32·	...	2·352	16	66	..	..
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	70·	52·2	34·	29·733	1·76	24	78	..	..
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	...	69·2	54·2	29·7	29·795	1·36	16	66	..	..
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	...	75·5	54·6	38·6	29·777	2·838	16	65	..	..
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ..	88·9	63·6	49·	29·872	5·53	11	65	..	..	W.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	134	66·5	51·2	37·	...	5·635	23	80	..	..

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

NOTES ON A CASE OF EXTRIPATION OF THE UTERUS FOR CANCER.

READ BEFORE THE N. S. WALES BRANCH, B.M.A.

BY RALPH WORRALL, M.D., HON. ASSIST.
SURGEON TO THE DEPARTMENT FOR DISEASES
OF WOMEN, SYDNEY HOSPITAL.

THE question of Extirpation of the Uterus for Cancer being at the present time much debated both in Europe and America, I have thought it right to bring before you a report of a case in which the operation was performed by me, and which, although unsuccessful, nevertheless presented much to encourage the performance of the operation in cases not too far advanced.

M. D., aged 33, applied for treatment at the out-patient department of the Sydney Hospital, with the following history:—Married 14 years, 6 children, no miscarriage, last pregnancy 6 years ago. Courses had been regular, and health good until 8 months ago, for which time there has been a constant bloody discharge. For the last month she has been losing flesh, backache and bearing down pain have troubled her, and the discharge has acquired a foetid smell. Her condition was that of a fairly-nourished woman, with a rather anxious countenance, but showing no marked cachexia. Pulse 120, soft and compressible. On examination the mucous membrane of vagina and cervix was normal, but os was patulous, and inside felt ragged, hard, and rough. The examination caused so much haemorrhage as to necessitate a plug.

On admission to hospital the fundus was scraped, and the debris submitted to the microscope showed numerous flat epithelial cells in tubular columns. The sound passed four inches. On Oct. 25th, 1886, I operated in the following manner:—The patient was placed in the lithotomy position, her legs flexed and supported by assistants. The bladder having been emptied and the vagina washed out, I cut into Douglass' space sufficiently to insert my finger, which I then used as a guide in passing needle and ligature through vagina and peritoneum, as each portion was tied it was cut through until the broad ligaments were reached on either side. The left vaginal artery gave some trouble, but was secured by a Spencer Wells' forceps. I then cut into the anterior cul-de-sac, guided by a sound in the blad-

der; this, with the cellular tissue containing the ureters, was pushed up as high as possible. I then attempted to introduce a thick sound into the uterus in order to retrovert it; finding, however, that traction on the cervix had caused it to separate from the body above the vaginal junction, I tied and cut through the still undivided lateral vaginal strips and removed the cervix; then inserting my hand into the abdominal cavity, the abdomen being at the same time pressed down from above, I succeeded in retroverting and pulling down the body of the uterus with the Fallopian tubes and ovaries. So much difficulty was experienced in endeavouring to ligature the broad ligaments that they were clamped instead with long Spencer Wells' forceps, and the uterus cut away. A plug of iodoform gauze was inserted, the intestines showing a great tendency to prolapse. The operation lasted two hours. The patient was propped up in bed so as to favour drainage. A $\frac{1}{4}$ -gr. morphia suppos. was inserted into the rectum, and 3ss brandy in digested milk. The pulse 126, immediately after the operation fell to 100 in an hour. The catheter was ordered to be passed every sixth hour. A morphia suppos. as often as might be necessary to prevent pain, and nutrient enemata every sixth hour. Only iced water by the mouth.

The following is an epitome of the history after operation:—There was some pain and tenderness in the lower part of the abdomen and occasional vomiting, but never any evidence of general peritonitis. A cough, caused apparently by the ether, troubled her a good deal. The temperature, 101·4 on night of operation, fell to n. on the 3rd day; the pulse varied from 100 to 120; 3xx to 3xl of urine were passed in the twenty-four hours; the vaginal plug was removed on the 2nd day—it had to be peeled off intestines at vaginal roof; the vagina was washed out with warm carbolic lotion, 1 in 40, and a smaller plug inserted. The intestines were felt to have formed adhesions to the cut edges of the vagina. The pressure forceps were removed 66 hours after operation. The nutrient enemata were stopped on the 6th day, as for the previous 24 hours patient had been taking peptonised milk and beef tea by the mouth. So far her condition had been most satisfactory, but on Nov. 1st, the 8th day, she began to complain of pain across loins, a watery discharge in considerable quantity flowed from the vagina, the temperature, n. in the morning, went up to 103 at night, and the pulse increased from 100 to 144 in the same period. She was very restless, but showed no sign of peritonitis. Ordered quinine gr. x. in a draught, and brandy in 3ii. doses

every 2 hours. Next morning the temperature had fallen to 101°, and p. to 126, but very weak. The extremities were cold and clammy. The urine contained muco-pus, and there was an immense discharge of watery yellowish pus from the vagina. All attempts to rally her from this low condition were unavailing. The temperature fell to 97°, the pulse became thready, her restlessness increased, and death took place on Nov. 5th (the 11th day).

The *P.M.* was performed by Drs. Clay and Wilkinson, 8 hours after death. Body showed signs of wasting. Rigor mortis marked. No sign of general peritonitis; but slight deposit of lymph over coils of intestine in the pelvis, which were adherent to cut edges of vagina, forming its roof. The portion of the broad ligaments which had been grasped by the forceps was in a sloughy condition. The cavity of the pelvis contained about a teacupful of watery yellow pus. There was a circumscribed abscess in the right side of the pelvis. The right ureter for about two-thirds of its length was dilated to three times the normal size, and was found to lead into aforesaid abscess. Right kidney was infiltrated with minute purulent deposits, and its capsule adherent. The bladder contained pus. L. kidney and ureter n., other organs n.

Remarks.—The course of events was probably as follows:—The right ureter had been grasped by the forceps, which secured the right broad ligament. The injured part sloughed about the 6th day, allowing the escape of urine into the cellular tissue and pelvic cavity; abscess followed, from which purulent infection of the kidney took place. The sudden change for the worse which occurred on the 7th day, when convalescence seemed firmly established, is thus accounted for:—The special dangers of the operation, shock, hemorrhage, peritonitis, and septicæmia had all been successfully avoided, and the *P.M.* gave every reason for thinking that, but for this untoward accident, the patient would not only have recovered from the operation, but probably not have had a return of the disease.

Dr. Wilkinson kindly examined the growth microscopically, and pronounced it an epithelioma commencing about the int. os, and spreading upwards and downwards.

It is likely that injury to the ureter is a much more common cause of death than published reports would lead us to suppose. *P.M.* examinations have not always been obtained, and, unless carefully searched for, an injury to a ureter may escape notice. Spencer Wells, in "Abdominal Tumours," p. 176, says: "I do not yet see any mode of certainly providing against the mischance of tying or dividing one or both ureters. I fear

that with all possible care it is an accident which may prove unavoidable."

Professor Olshausen, in a letter to Spencer Wells, urges that injury to the ureters is *the great danger*. Mr. Jennings, in the *Lancet* for May 1st, 1886, points out that when ovaries and tubes are removed the risk of injuring the ureters is much increased. Nevertheless, I think that as the tubes are parts of the uterus, and as the ovaries when left have, in several cases, been a source of periodic danger and distress, it is a more complete and satisfactory operation to remove them when possible.

I am inclined to believe that the ligature is a better means of securing the broad ligaments than the forceps. It occupies less space, the ureter is less likely to be injured, and the adhesions are not disturbed by the removal of the forceps. If the latter are used they should be removed in 48 hours, in which time the vessels would be occluded, and the tissues would not be so injured by the compression as to slough and be a possible cause of septicæmia. If the intestines show a tendency to prolapse on removal of the uterus, from diminished retentive power of the abdomen, it would be wise to suture the edges of the peritoneum together to an extent sufficient to prevent this, and so avoid the necessity for a large plug, which tends to hinder the desired adhesion between post surface of bladder and post vaginal wall.

I pass over many other interesting points connected with different modes of performing the operation, and come to the all important question—Is this operation justifiable? If so, under what circumstances? I take the following information and statistics from an exhaustive paper by Sara Post, in the first number of the International Journal of the Medical Sciences:—Professional opinion in Germany is unanimously in favour of the operation. In America a large majority, and in England a minority favour it, while in France only one or two recognise it as a legitimate procedure. It is noteworthy that those surgeons who have seldom seen or performed the operation are its strongest opponents, and *vice versa*. Comparing it with operations for Cancer in other parts of the body we get the following results:—Of 137 cases of cancer uteri for which *kolpo-hysterectomy* was performed by Schroeder, Olshausen, and Martin, 97 survived the operation, and 20 per cent. remained well at the end of two years. Of 131 cases of extirpation of the breast for cancer by Volkman, 121 survived the operation, but only 15 per cent. remained well at the end of two years. Showing that although extirpation of the uterus is a much more dangerous operation than extirpation of the breast, yet those who recover from the former operation have a better

chance of escaping a return of the disease. Even when it does recur we have gained much. There will be less pain, no discharge, we have enabled the poor sufferer once more to feel "the joy of living," given her complete immunity from all her troubles, for a time, at all events, restored her, as she happily thinks, to perfect health.

Then we must remember how different is this disease from others, for which dangerous operations are performed. Take uterine fibroid or ovarian cystoma. In the former we may hope that, if the patient can struggle on until the end of menstrual life, the growth will atrophy and disappear; and an ovarian tumour, as we all know, can exist for years without destroying life, may even cease to grow. In the case of cancer how different are the circumstances, no ray of hope can ever illumine the dark prospects of the unhappy sufferer, exhausted by haemorrhage, wracked with pain, rendered abhorrent to herself and those around her by the foetor of the discharges, the death which comes swiftly and surely is welcomed as a friend. Is it not an opprobrium on our art that we should stand by, with folded arms, without one effort to avert this dreadful doom? Should we not rather, throwing aside timorous fear, hope that by increased experience, improved methods, and early operation, we may so diminish its mortality, and improve its results, as to raise this operation to a foremost place in the triumphs of surgery.

PESSARIES.

By W. V. JAKINS, L.R.C.P., L.M., EDIN.; FELL. OBST. SOC.

IN the *A. M. Gazette* of October, I published a few introductory remarks on the use of Pessaries.

I now purpose saying a few words on some that are hurtful to the patient.

1. *Large solid* pessaries, as kept by every chemist, of boxwood, metal, vulcanite, composition, in shape globular, oval, discoid, pyriform, all give temporary relief; all exaggerate the weakness which results in the uterine displacement by still further dilating the vagina, and thus commonly the size of the instrument has to be continually increased; all usually induce leucorrhœa, sometimes with hardening about the os, sometimes with ulceration, in some cases the suspicious precursors of cancer; all occasionally become encarcinated, causing ulceration, and it may be death.

2. *Lint, tow, linen, sponge*, on the same principles are likewise injurious, although to a lesser degree.

3. *Pessaries requiring external fittings* as Garrel's inflating I. R. instruments of all shapes and sizes; those with I. R. suspenders as Coxeter's, Napier's, and Schofield's; those with solid suspenders, as Tracy's, Wilkie's, Magennis', Duffin's, Clay's; all this class, especially in our warm summers, cause chafing and leucorrhœa, and have to be laid aside.

4. *I. R. rings of large thickness*, however shaped, soon become indented, vaginal secretions lodge in their depressions and rapidly become offensive, illustrating the almost proverbial phrase, "as bad smelling as an old pessary;" the thick spring instruments also continue the dilatation of the vagina and may cause some of the mischief detailed under Class 1.

5. *Fowler's Pessary*, vulcanite, like a milk bucket with the bottom out of it, I have seen cause much suffering from being so easily impacted; fortunately it is so difficult to introduce that the patient is usually too lightly fitted and the instrument falls out.

6. The same remarks apply to *Blackbee's*, a spring high saddle-shaped instrument, like a Fowler in outline.

To me the *Ideal Pessary* is *Hodge's Ring*. For the past 18 years I have seldom used any other. At that time they were not to be bought, I had to make my own and still use them; copper wire to loosely fit a piece of I. R feeding bottle tubing is all that is necessary. I have known it to be worn for 9 years untouched without being affected; on removal it looked like a new instrument. *Zwank's Vulcanite*, with screw handle, has given me very good results. Most uterine displacements can be successfully treated with a complete assortment of these two Pessaries.

Stems require much care and generally some preparatory treatment of the patient—those with external fittings as Cutter's and Simpson's, and those with internal fittings as Hewitt's padlock and Wynn's padlock, are best avoided. I. R. stems with wings are occasionally of service. Of spring stems the vulcanite are the best; they should be cut out of solid vulcanite, even then they are apt to lose their resiliency and become brittle. The plain vulcanite stem is that which I most commonly use.

To sum up: for all ordinary purposes, if the practitioner procures a complete set of Hodge's rings (Hewitt's I. R. variety), and of Zwank's vulcanite with screw handles, he will be able successfully to treat most uterine displacements. If he desires to go further and use stems, then a complete set of I. R. winged stems, and of plain vulcanite stems will suffice for most cases.

A CASE OF ACCIDENTAL VACCINIA— RESULTING IN DEATH.

BY MELVILLE JAY, M.R.C.S. ENG., L.R.C.P.
LOND., OF NORTH ADELAIDE, S.A.

The following case is, I think, worthy of being placed on record, on account of its rarity, the difficulty of early diagnosis, the unfortunate termination, and the lesson to be learnt from it.

Mrs. R—— had two children, aged 2½ years and 8 months respectively. The younger child suffered from infantile eczema from two months old, and was off and on under my treatment during this time. The skin affection was limited to the face, ears, neck, affected the forehead slightly, and spread down the chest to the level of the third rib.

On June 30th of this year I vaccinated with human lymph the elder child in the ordinary position, and the vesicles ran through their customary course with very little surrounding inflammation or constitutional disturbance.

On the morning of July 20th, Mrs. R—— brought her infant to my consulting rooms, saying he had been taken ill four days previously with sickness, feverishness, restlessness, &c., and the eczema of the face had broken out afresh, also that on the previous day, the 19th, his first tooth had come through. I looked at the child's face, I am sorry to say, in rather a hurried and careless manner. The skin presented a roseolous condition at the edges of the patches of eczema, which was dry and squamous in character on the forehead and chest, moist on the cheeks, neck and ears, without much crusting or thick scabs. I jumped at the conclusion that the child was suffering from a recrudescence of his old complaint, aggravated by the teeth irritation, and I treated him accordingly. The child was slightly feverish and irritable, and the mother found great difficulty in keeping his hands from his face.

Two days after this, i.e., on the sixth day after the onset of the attack, I was called to see the child and, to my astonishment, found the face and neck covered with a vesicular eruption which, I remarked to the parents at the time, closely resembled small-pox of a confluent type. Numerous isolated vesicles with commencing central depression were scattered over the forehead, on the nose and eyelids, and on either side of the patch on the chest; there were three or four vesicles on both hands, and one over left hip. The cheeks, ears, chin, front of neck, and upper and central part of chest were covered completely with a confluent mass of vesicles, which had in parts become softened and macerated by the local remedies used, which consisted of a lotion containing oxide and carbonate of zinc, glycerine and rosewater, occa-

sional poultices, and bathing with thin gruel water. Temperature, 101 deg. Beyond the irritation caused by the rash, the child did not appear to be suffering to any great extent, although the mother informed me he had had little or no sleep for the previous three nights. I informed the parents that I had never seen a case of eczema undergoing such a change, and presenting similar characteristics, and I suggested the advisability of further advice.

Consequently, on the following day, a week after the commencement of the illness, Dr. Verco saw the case in consultation with me, and suggested what was without doubt the origin of the disease, viz., that the raw eczematous surfaces of the infant's head and face had become infected with the virus from the vaccine pock on the elder child's arm. On enquiry I found that, contrary to custom, the two children had been allowed, for several nights prior to the infant's illness, and before the elder child's vaccine vesicles were thoroughly healed, to sleep in the same bed; and it seems highly probable that it was during this time the infant became inoculated.

The case went on quite as well as one could expect up till the fourteenth day. The temperature, which had risen as high as 102 deg., had then subsided to normal. There was a slight attack of diarrhoea lasting only one day; there was little or no inflammation surrounding the eruption. The child had taken food well up to this date, consisting mainly of mother's milk for the first few days, white of egg and brandy, and Nestle's food. After the irritation subsided, the child slept fairly well; soothing lotions had been applied, and the face dusted with a powder of zinc and starch, and poulticed. Most of the crusts about the face and mouth had by this time loosened off; the skin beneath appeared to be less affected than I had anticipated.

The mother who had nursed the child up to the fifth day of illness, and who had not been vaccinated since infancy, although she had one distinct vaccination mark on her arm, developed several well-marked vesicles on both nipples and breasts, one in right anterior nares, on left lower eyelid, on left cheek, and two or three on side of neck.

These all ran through a typical course of vaccinia, and gave rise to a considerable amount of lymphatic inflammation. No others in the house were affected, although the father suffered from a sharp attack of diphtheria, commencing two or three days before the child's death. On the fourteenth day the child for the first time seemed unable and unwilling to take any food, symptoms of collapse set in, and the mucous

membranes became very blanched. I endeavoured by all stimulating means to keep the child's strength up, but he gradually sank and died on the following day.

There can be no doubt, I think, as to the correctness of the diagnosis in this case—and I have to thank Dr. Verco for giving me the clue to the elucidation of the case, as I confess I was puzzled to account for the uncommon complication.

The main points which suggested themselves in distinguishing the case from one of small-pox were—

(1). The absence of any other case of small-pox in the vicinity, and the knowledge that the child had come into contact with another child suffering from broken and running vaccine vesicles for some days prior to commencement of eruption.

(2). The absence of the characteristic fever of small-pox, and of the typical shotty papules.

(3). The distribution of the eruption being limited to those parts which were at the time effected with eczema, with the exceptions previously mentioned, and I think one can satisfactorily explain their presence by direct contact, except in the case of the solitary vesicle over the hip, and a child might very easily carry contagion in its nails to such a portion of the body.

(4). The mother being affected only in those positions where she might have been—in fact she declares she was—scratched by the infected nails of the child.

(5). The absence of any characteristic smell of small-pox, or of the usual constitutional symptoms attending that disease.

(6). The vesicles ran the ordinary course of vaccinia, with little or no formation of pus or pustules, as in small-pox.

The moral to be drawn from this unfortunate case is that every medical man should exercise great care in preventing an absorbing surface, such as is presented in cases of eczema, coming into contact with vaccine virus: in fact, I think it would be as well to make a rule never to vaccinate one child of a family while another was suffering from eczema in anything like a severe form, in case any accidental inoculation should take place.

Now, the question presents itself: is it right to vaccinate a child while suffering from a skin affection like eczema? Personally I do not see any reason why a child suffering in this way should not be vaccinated, provided due care is taken to keep the virus from contact with the eruption. By the time the vesicles had developed, the child would be protected, and no amount of contact of the vaccine lymph with the absorbing surfaces of the rash would, I should imagine, produce any effect.

I might mention, to make matters still worse in this case, Mrs. R. informed me that she had lost her eldest child some few years previously seventeen days after being vaccinated; at the time of the child's death the vesicles had developed into large and deep sloughing sores, and although the medical man in attendance had assigned a different cause for death, the parents naturally enough attributed it to the effects of vaccination.

TOTAL EXTRIPATION OF THE UTERUS BY THE VAGINA FOR CARCINOMA —RECOVERY.

READ BEFORE THE S.A. BRANCH B.M.A.

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WHETHER or not we are yet justified in conceding to extirpation of the uterus for carcinoma a place amongst the operations of surgery which are both established and justifiable, the conspicuous success which has attended this operation in the hands of Martin, Schröder, Billroth, and other surgeons, renders it extremely probable that it will take such a place in the near future. Indeed, there is even now no question as to the perfect feasibility of the operation, and as to the frequency with which recovery from it takes place.* That which is less well established is the question how far the operation will be found of ultimate benefit as regards the prolongation of life or the relief of suffering. On this point the data are still insufficient, I think, to enable us to form a decided opinion.

I venture to offer these notes to the Society, partly as a small contribution to the rapidly accumulating record of such cases, and partly because I think the less common operations, especially when they are difficult and dangerous, are worth

* Out of 235 cases collected by Dr. Guserow (Deutsche Chirurgie, 1886), in which the uterus was removed by the vaginal method, there was a mortality of 28·3 per cent. This list includes many of the earliest operations, dating from 1822. In 36 cases performed after 1882, the mortality was 8·8 per cent.—*Lancet*, May 1, 1886.

recording. Further, knowing how glad I was to avail myself of the experience of other surgeons, and how much I learned from their published reports, I think it is possible that these notes, recording, as they do, dangers and difficulties, mistakes as well as ultimate success, may be of some assistance to others who are seeking similar information and experience. I believe also I may claim that this is the first successful case precisely of this character that has been performed in South Australia, though I am well aware that Dr. Görger reported to this society last year a case of recovery after removal of the uterus for fibroids, in which he combined a vaginal incision with an abdominal section.

M. S., aged 37, a healthy-looking woman, was admitted to the Beatrice Ward of the Adelaide Hospital, under the care of Dr. Verco, on July 16, 1886. I extract the following particulars from Dr. Verco's ward book :—

The patient complains of aching pains in the lower part of the abdomen, which have been experienced for about nine months. She is married, and has had nine children, of whom the youngest is seven months old. One miscarriage preceded the birth of the first child, and the last confinement was lingering and attended with some *post partum* haemorrhage. Since that event there has been continuously a thin watery sanguineous discharge from the vagina.

On examination :—Abdomen flaccid, not prominent; some tenderness on palpation over umbilical and supra-pubic regions; vagina roomy; cervix uteri low down, large, and somewhat flattened out, fairly movable and directed backwards, the os admits the finger point, anterior lip short, both anterior and posterior lips covered with lobular masses, which break down easily under touch, and bleed considerably; vaginal walls smooth and free from any outgrowth or irregularity; tongue pale and flabby; gums and conjunctiva of normal aspect; bowels regular; appetite fair; pulse, urine, and temperature normal. She was ordered a diet of milk and beef tea, and a mixture containing bromide of potassium and liquid extract of ergot.

On repeating the vaginal examination a few days subsequently, the uterine sound was found to pass readily about $4\frac{1}{2}$ inches in the normal direction, bleeding again recurring somewhat freely after the manipulation. On this occasion (July 23) the inner surface and lips of the cervix were scraped by Dr. Verco with a sharp spoon, and numerous soft friable masses of the growth removed, with the result of leaving the walls of the cervix bare and thin, the os then admitting two fingers. There was some little haemorrhage attendant on the operation. A tampon of

glycerine and tannic acid was introduced into the os, and a draught of liq. opii sed. ordered.

Microscopic examination of the fragments removed confirmed the obvious diagnosis of epithelioma.

Little relief to the symptoms followed this treatment, and the growth having speedily recurred, Dr. Verco asked me to see his patient, with a view to the adoption of some more radical procedure. I accordingly did so, and found substantially the same condition of things as described on her admission, with a similar tendency to haemorrhage on manipulation.

In view of the fact that the disease was apparently entirely confined to the cervix and internal surface of the uteruses, and that the organ was not unduly enlarged, and fairly movable, it appeared to me a very proper case for the removal of the uterus by the vagina, and, my surgical colleagues concurring in that opinion, the patient consented without hesitation to undergo the operation, of which the risks were unreservedly represented to her.

As I had not before undertaken this operation on the living body, I postponed the performance of it on Mrs. S. until I should have had some opportunities of doing it a few times upon the cadaver, a course which was of the utmost advantage to me.

Eventually the operation was fixed for September 11, at 9 a.m., the patient having been previously removed to the Ovariectomy Cottage. All the usual preliminaries were carried out—that is to say, the bowels were cleared by a purge administered on the two consecutive nights preceding the day of operation, and an enema early on the morning of that day. The vagina and vulva were well cleansed by washing with carbolized lotion from the douche, both the night before and on the morning of the operation. The pubes were shaved and the urine drawn off shortly before our visit.

Ether having been administered in an adjoining room, I operated with the assistance of my surgical colleagues—Drs. Gardner, Görger, Jay, and Giles, Dr. Verco also being present, and all the usual antiseptic precautions, except the spray, were adopted.

The patient being secured in the lithotomy position, and the vagina once more washed out and held widely open by broad flat spatulae, a male sound was held in the bladder; the uterus was well drawn down with a vulsellum forceps, and the cervix transfixated with a thick double silk ligature well behind the limits of the growth. Anterior and posterior incisions were made, similarly well clear of the disease, through the tissues covering the cervix, and through these

incisions the tissues were separated before and behind from the substance of the uterus by means of a scalpel handle, blunt pointed scissors curved on the flat, as well as by the fingers. This was done easily enough on the posterior surface, but in front it was a matter of considerable difficulty, owing to the extreme adherence of the uterus to the bladder, due, it appeared even then to me, to the close encroachment of the disease towards that surface. The greatest care, therefore, had to be taken to keep close to the uterus, so as to avoid wounding the bladder. The peritoneum in front and behind was then opened by transverse incisions, and, with a little more separation of the parts by the fingers, the uterus was apparently freed from its attachment, save to the broad ligaments on each side. I then felt sure that the fundus could be sufficiently tilted forwards to be dragged outwards through the vagina, but owing to the length of the organ and the shortness of my own fingers, I was unable to reach up far enough to effect this manœuvre. Thanks, however, to the long and dexterous fingers of Dr. Gardner, inserted behind the organ so as to tilt it forwards, combined with the assistance of a Barnes's sheathed polypus hook inserted into the front of the fundus, the body of the uterus was forcibly anteverted and dragged forwards and outwards through the vagina; thus I was enabled to pass a second stout double ligature through the fundus, which gave a sure and excellent control over the organ for the remainder of the operation.

By this manœuvre I should have been enabled to draw down the uterus sufficiently far to place ligatures on the broad ligaments, but there was considerable difficulty in doing this, for the reason that in the first incisions encircling the cervix, I was not sufficiently careful to join the anterior and posterior incisions on the right side, and the band of mucous membrane thus left incompletely divided was the hindrance. Remedying this oversight as well as I could, I was eventually able to draw down the uterus sufficiently far to get hold of the whole broad ligament of the left side. Transfixing it, I tied it, without including the ovary, with strong carbolised Chinese silk (which material was used throughout the operation), first in two halves, and then again as a whole, leaving the ends of the ligatures long. I then cut through the ligaments between the ligature and the uterus, and for additional security I tied separately one conspicuous vessel in the severed stump of the now ligatured broad ligament.

I was then free to deal with the right side, but here I encountered this additional difficulty, viz., that in drawing down the uterus, part of the organ broke away under the tension, and left a portion

of the diseased structure attached to the broad ligament. Applying a ligature temporarily, I freed and removed the whole of the uterus, except that fragment of diseased tissue which, as before said, remained attached to the broad ligament. With some difficulty I was able to draw down this fragment sufficiently to transfix and ligature the broad ligament as on the left side, well above the diseased part, which was then removed. In this case, however, the ovary was included in the parts removed. Further trouble here awaited me, for, on completion of the section, one of the ligatures placed on the stump slipped, allowing a large vessel, probably the right uterine artery, to bleed profusely. This was speedily secured and tied, but there was still considerable haemorrhage, which came apparently from a number of small vessels so far up in the remotest recesses of the large cavity now left that there was the greatest difficulty in arresting it. Forceps after forceps was applied, and at last, after the application of eight, the bleeding seemed to be checked. Here I will say that much of my difficulty would have been removed if I had possessed artery forceps much larger and stronger than those in ordinary use, which, by their shortness, were quite inadequate for working in a cavity of such depth. To lessen further the risks of haemorrhage, several well carbolized sponges, with strings attached, were jammed up against the surface whence the bleeding proceeded. The vagina was then washed out with the douche; a T-shaped rubber drainage tube of large calibre inserted as far up as possible, with the cross piece lying transversely across the upper part of the cavity, between the tied ends of the broad ligaments; some plugs of carbolized gauze well powdered with iodoform, and attached by strings inserted into the vagina, and a large pad of a similar character, supported by a T bandage, placed over the outside of the vulva, through the orifice of which the handles of the artery forceps, as well as the drainage tube, and various ligatures just protruded. No attempt, it will be observed, was made to suture the cut edges of the peritoneum. The whole operation lasted a little over two hours, and on its completion the patient was much blanched, with a pulse scarcely perceptible, but on the subcutaneous injection of ether, the circulation revived perceptibly, and she was shortly moved into her bed.

For the subsequent course of the case I will, as briefly as possible, summarise the notes of the case, taken by the House Surgeon, Dr. Aitken.

Recovery soon took place from the effects of the anaesthetic, and was followed by considerable sickness, which appeared intensified by the small quantities of brandy which were ordered to be given as soon as she should be able to swallow;

champagne was therefore substituted with some benefit, but for three or four hours the pulse remained exceedingly weak, and she complained much of severe pain in the back. One-sixth of a grain of morphia was injected subcutaneously. At 3 p.m. the pulse had much improved, being 104 and soft, and the pain in the back was less. Between 3 and 7.30 p.m. she slept a little, but, the pain becoming more severe, the morphia injection was repeated. At 10.30 p.m. the pulse was 120, and the patient was retching a good deal; at midnight the injection was repeated, and the external pad, through which some oozing appeared, was changed. During the remainder of the night she slept at intervals, and was, on the whole, reasonably comfortable, taking frequently small quantities of champagne, milk, and chicken broth.

September 12.—On the following morning two of the sponges and all the eight artery clips were removed, no fresh haemorrhage following. The vagina was well irrigated with $\frac{1}{10}$ per cent. warm solution of thymol, and then plugged with tampons made of salicylic wool, well dusted with iodoform, enclosed in small bags of carbolized gauze, each bag being secured by a string for its easy removal. Temp., 99.6; pulse, 120; tongue, clean and moist. She slept about two hours during the course of the day, and did not suffer much pain; in the afternoon the remaining sponges were removed, some dark red bloody discharge following, quite free from any putrefactive smell. The labia were slightly swollen. The vagina was again irrigated with the thymol solution from the douche, and the iodoform tampons, as well as the external dressings, changed. During the evening she slept frequently at intervals, and was fairly comfortable. Respiration 20; pulse, 134.

September 13.—In the early morning she was very restless, complaining of great pain in the bowels, and vomiting frequently. Pulse, 136; temp., 98.6. Morphia injections were continued at intervals, with the result that both pain and sickness gradually ceased. Dressed as before both in the morning and afternoon, and ordered some jelly in addition to the milk and beef tea.

September 17.—The T-shaped drainage tube was withdrawn and replaced by a straight piece of similar material.

From this date the favourable progress of the case renders it unnecessary that I should continue in detail the daily record. I will, therefore, sum up the subsequent course of events by saying in general terms that the progress towards recovery was uninterrupted, save for some slight digestive disturbances. The discharge, at first scanty and sero-sanguinolent, increased until it became copious and purulent, but with never more than a

slight odour of putrefaction. As the discharge increased, so were increased the frequency of the dressing and douching, and conversely. For many days this performance caused the patient much distress, from the severe scalding pain arising from extreme tenderness and excoriation of the labia, both internally and externally, but this pain ceased almost immediately on completion of the dressing, and after its cessation, she invariably expressed herself much more comfortable than before. The application of vaseline, both before and after the douching, was found to give great relief in respect of this pain.

September 14.—Vomiting has ceased since the previous evening, but she complains of heartburn, for which a little bicarbonate of potassium was ordered. Dressed as before in the morning and afternoon. Pulse varying from 120-130, and temp. from 101.4-102.2 during the day.

September 15.—Is feeling restless and uncomfortable from flatulence and a severe pain in the epigastrium, for which she was ordered a mixture of sal volatile, sp. chloroformi, and tinct. cardamom. co. in peppermint water, to be taken occasionally.

September 16.—Slept well during the night, and is much refreshed in consequence. The pain and flatulence have also much diminished. For the first time there is the slightest possible abdominal tenderness. Pulse, 120; temp., 101.2. From now onwards irrigated, and dressings changed three times in the twenty-four hours, in place of twice as heretofore. Discharge slight, but increasing in quantity, barely blood-stained and quite sweet. The abdominal pain ceased towards evening, and the patient was comfortable.

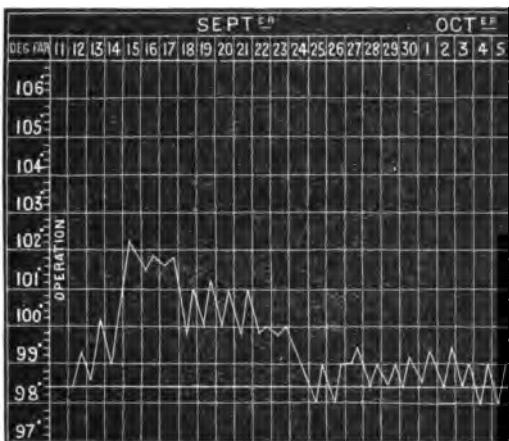
The same kind of tampons and external pads were used throughout, the strings allowing the former to be easily withdrawn and changed.

The bowels were opened naturally on the seventh day after the operation without pain or trouble, and she was allowed some fish as a commencement of a solid diet on the following day. Subsequently the bowels were opened occasionally by the administration of a simple enema, and later by an occasional dose of Carlsbad salts.

The use of the catheter until then regularly used was discontinued on the thirteenth day, the urine being thenceforward passed naturally, without pain or difficulty, and being in all respects normal in character. On September 24, thirteen days after the operation, the ligatures on the left side all came away together on slight traction being made, a small slough being attached. On October 1, all the ligatures on the right side, as we thought, were similarly removed, except one, which came away three days later. She was then allowed to get up, and on the 6th October she

was able to walk a little, feeling as her chief trouble the weakness of her ankles.

TEMPERATURE CHART.



On the 9th October she returned to the general ward, the discharge having almost ceased, and the vagina being washed out once a day only, and on the 18th, having regained her strength to a considerable degree, she was sent to the convalescent Hospital at the seaside, where she is instructed to remain a month, and then return here to report herself.

The following is a brief account of the condition of the parts removed:—

Greatest length of uterus, four inches; breadth at fundus, three inches; thickness of walls, about three-quarters of an inch. Os tumid, ragged, eroded and friable; canal of cervix obliterated. The disease had encroached on the anterior wall for only an inch from the os. There was no evidence externally of the extension of the disease towards the posterior surface, but a section through the organ showed that there was some infiltration of the tissues in that direction also. Internally the mucous membrane was blood-stained and apparently affected by the disease throughout the lower two-thirds. On microscopic examination a section through a piece of the eroded border showed a structure consisting chiefly of closely aggregated small round cells, with a small and varying amount of stroma. Here and there, throughout the muscular substance, were groups of cells of a distinctly epithelial type, and a few typical epithelial nests were also observed.

These appearances sufficiently indicated the character of the growth as epithelioma.

Remarks.

With a very limited experience of this operation, I am doubtful of the value of any observations I may make, and if I venture to offer them,

it is only to those who, like myself, are seeking information and experience.

In the first place the operation is one of great difficulty, and should never be undertaken for the first time without repeated practice on the dead body, and a careful study of a dissection of the region involved. By the assistance and courtesy of the Professor of Anatomy, Dr. Watson, I had every advantage in these respects, and I found the information and experience thus gained simply invaluable.

The chief dangers, of course, arise from the risk of wounding either the bladder in separating the anterior surface of the uterus from this organ; the ureters, to which one comes perilously near in tying or dividing the broad ligaments; or the rectum and intestines, one or both of which may come awkwardly in the way. The difficulties arise primarily from the fact that one has to steer clear of all these risks whilst working at the bottom of a deep and narrow cavity with the view often obscured by blood. In my case the separation of the uterus from the bladder required especial care, as these organs were more than usually adherent, and I consider myself fortunate in having avoided this material complication. The rectum came well into view, and bulged forwards somewhat, but it never became a source of trouble, being very easily pressed back out of the way. I had no trouble from prolapsing of the intestines, but I noticed that this occurrence caused much inconvenience in some of the reported cases.

As to the relative advantages of the two methods of securing the broad ligaments, namely:—that of carrying a ligature round them *in situ*, or that which I adopted of antevertting the uterus, and bringing its fundus out by the vagina, I hesitate to speak, but I incline to the latter as giving the best facility for applying the ligature. If, however, the uterus is long and the vagina narrow, it is not at all an easy manoeuvre to perform, but the operation is materially facilitated by the use of Barnes's sheathed hook, as described above. So far as my experience on the cadaver goes, the upper edge of the broad ligaments lies at a very variable distance in different subjects. In cases in which this was not great no considerable difficulty was experienced in hooking a ligature round them, and by this means in bringing them sufficiently within reach to transfix and tie with safety and security; on the other hand in those cases where the edge is situated far up it is very difficult not only to pass the ligature but also to be certain that the whole of it, and nothing more than the whole, is enclosed.

Schröder of Vienna recommends *retroverting* the uterus and so bringing out the fundus through

the posterior *cul de sac*, but this appears to me more difficult still than the plan of anteversion which I adopted.

Another source of obvious trouble that is noticed by most operators, and which I have recently seen exemplified to a considerable degree in a case of Dr. Way's, is the liability of the diseased and softened tissues to break away under even a very moderate strain when pulled upon by the vulsellum or ligature. This of course can scarcely be wholly obviated in some cases where there is extensive disease, but the liability to the accident is obviously lessened by using only a very broad bladed vulsellum and thick ligatures for holding purposes, and by applying these to healthy tissues, or at least to tissues as far as possible from the diseased structures. I was, on the whole, fortunate in this respect.

I have already remarked upon the haemorrhage in my case which threatened to be dangerous. This was in great part due to my initial fault of not thoroughly dividing the mucous membrane around the cervix, and so allowing the uterus with its attachments to be more freely drawn down within reach, but even under the circumstances the trouble would have been more easily obviated if I had possessed longer and stronger artery clips.

The treatment adopted requires little further notice. The main point, of course, being thorough drainage, and the prevention, as far as possible, of putrefactive changes, by frequent douching with antiseptic lotions, and by the presence of antiseptic tampons. For drainage the T-shaped rubber drainage tube, made in a very simple manner by sewing the end of one piece to the edges of a hole of corresponding size in the middle of another, answered very effectually, the tube being large enough to allow of the insertion in it of the nozzle of the irrigator. The lotion used for irrigation was 1-10th per cent. solution of thymol, which has been that adopted in many of the recorded cases. In my own case I had every reason to be satisfied with it, for at no time was there more than a very slight putrefactive odour. Indeed, considering the locality, it would seem impossible to avoid this entirely.

I have no experience of Mikulicz's permanent irrigator which is used by some surgeons, but it appears to me from the accounts of those who use it that however efficient it may be for drainage purposes, it is attended with several inconveniences, notably those of discomfort to the patient.

The tampons of salicylic wool, impregnated with iodoform, were used throughout, and seemed to answer their purposes admirable as an anti-septic.

In connection with the question of drainage, I must allude to a suggestion of Dr. Gardner, that the sitting posture is obviously calculated to promote drainage from the vagina, and, adopting that suggestion so soon as my patient was strong enough, she was propped up in a sitting posture occasionally during the day.

To avoid undue intrusion of details but little mention has been made in the report of the case of the temperature; this, however, is fully shown in the annexed chart. The chart shows the temperature at 6 a.m. and 6 p.m. only, but it was taken at first every three hours, and subsequently every six hours; the highest recorded temperature being 102·6 at 3 p.m. on the 16th September, which is consequently not recorded in the diagram. Though never very high, the temperature remained a considerable time above the normal, and was thus a constant reminder not to neglect frequent irrigation and dressing.

During the first few days after the operation the diet consisted of beef tea, chicken broth and, subsequently, calves-foot jelly, with small quantities of champagne and a liberal supply of ice, which was always very grateful. To this was added, as stated, some fish after the first action of the bowels, and gradually a solid diet of a light character was resumed, to which was added a little port wine. I may here mention that the patient stated that she had been all her life very abstemious. The only medicine given, besides those reported, was quinine during convalescence.

Mrs. S. is to return here after her stay at the Convalescent Hospital, and my only anxiety is that, as has so often happened in these cases, all our efforts may prove futile from a too speedy recurrence of the disease.

I am well aware that in the above remarks I have left quite untouched many important questions, notably that of the indications for or against the operation, but I feel I have already trespassed too long upon the time of the Society. At some future time I hope to bring the whole question before it for discussion.

In conclusion I have to thank my colleagues, especially Dr. Gardner, for their invaluable assistance during the operation, as also the House Surgeon, Dr. Aitken, for his cheerful and unvarying attention to the case at all times and seasons.

NOTE.—On the return of Mrs. S. to the Hospital, on the 14th November, after her sojourn at the Convalescent Home, I had an opportunity of examining her with Dr. Verco. She had improved very considerably as regards her strength and general health, being, as she said, better than she had been for many months. There was scarcely any discharge.

On vaginal examination :—The central parts of the divided peritoneum were well and firmly healed, but on each side, at points corresponding to the position of the stumps of the broad ligaments, there was a patch of rather dark, exuberant, and not very healthy-looking granulations. To that in the right side was attached a linear brownish-looking mass of what appeared exactly like faeces, but on seizing it with a forceps it came away completely and easily, and proved to be a ligature enveloped in old blood clot.

The patient was sent home, with instructions to return for inspection in a month.

AURAL AND OPHTHALMIC NOTES.

By B. SCHWARZBACH, M.D., L.F.P.S., GLASC., SYDNEY.

It is but natural that every medical practitioner, at the end of each year of his practice, passes a mental review of all the cases treated by him during the last twelve months, lingering with his thoughts on those which, in his opinion, are interesting and noteworthy. A specialist, whose practice is limited to the treatment of diseases of certain organs only, is probably still more inclined than a general practitioner to narrate the history of interesting cases. Thus in Europe, especially in Germany, regular yearly reports are published by ophthalmic and aural surgeons, giving, as it were, the result of the professional activity for each year. Statistical tables of occurrences, and the mode and result of treatment of certain diseases, form important chapters in the books of medical history and medical geography.

However, it is not my intention to publish here a report of all cases which came under my observation during the last year, or even to give an exhaustive history of certain cases. But I believe it will be welcome to members of the fraternity to hear some general remarks on the nature and frequency of some diseases belonging to the domain of my specialty.

First in regard to ear-diseases. I find that in New South Wales the chronic catarrh of the middle ear (*catarrhus cavi tympani chronicus*) is, comparatively, quite as frequent as in northern European latitudes. Over one-half of all the ear patients treated by me suffered from the same. In most of the cases treatment was applied for after the hardness of hearing had developed to a considerable degree, and it was therefore difficult—not so much to remove the primary cause of the affliction, but to alleviate the results of the cause. When the stapes has become more or less immovable, when swelling of the mucous, slime, and other secretion have lessened the swinging capacity in the oval window and in the membrana

rotunda, sound is made difficult to enter the labyrinth and to reach the acoustic nerve. Of course, even in cases where the affection of the middle ear has developed a high degree of deafness, certain sounds will always be transmitted to the nerve by the continuation of the bone (*processus mastoideus, os frontis, &c.*). Only, if the disease has extended into the central part of the organ, absolute deafness may occur. Happily, the chronic catarrh of the middle ear is not often thus complicated. With patience—with a great deal of patience on the part of the afflicted and of the physician—much good can be done by the ordinary well-known method, viz., Pollitzer's nasal catheter, attention to the Eustachian tubes and to the throat. Alas! the necessary patience is rarely to be found by the afflicted; for persons suffering from deafness are, more than persons suffering from other diseases, inclined, if relief is not obtained in a short time, to change the physician and the mode of treatment, or to despair and do nothing. These patients rarely take it into consideration that the arrest of the disease is a boon in itself. To a standstill the disease may be brought in nearly all cases, while, without proper treatment, deafness would increase in nine cases out of ten. In a "fresh" catarrh of the middle ear, restoration of the hearing can easily be effected, but cases of long standing are most difficult to be conquered. But, I repeat, even in such cases the improvement is often wonderful, if "orders" are obeyed. And the first "order" is—not to expect any decided improvement before some months after the commencement of the treatment. With only a few exceptions, patients who have been under my daily care for a longer time admitted to have been improved, and in several instances admitted to have been cured. (To be able to make this remark I am pleased, not only for the sake of the patient and for my own, but also in consideration of those medical practitioners who have placed the patients under my care.) In a case of a Mr. M—, of Manning River, where deafness had developed to a painful degree, and where verbal intercourse was nearly impossible, the patient, after two months daily treatment, left Sydney greatly relieved, although his hearing was still much subdued. He returned again after an absence of eight months, and called to let me know that his hearing has become completely restored, and that the roaring in his ears has entirely ceased. And this was effected by the simple, though long-continued, after treatment: gargle-water, Salvator's Trial, small doses of potass. of iod., an occasional foot-bath, and, of course, general care to the system.

The noise in the ears is to the patients often quite as distressing as deafness itself. Its origin

is, self-evidently, of various nature. In simple cases of a chronic catarrh, the noise generally originates by a pressure of the tympanum on the little chain of bones in the middle ear, the stapes consequently producing a pressure on the labyrinth. That the air in the cavity of the middle ear becomes lessened, and thus drawing (sucking as it were) the drum inward, is a well-known fact. A contraction of the musc. tens. tymp. may also produce a pressure on the labyrinth.

When the hearing improves, in cases of catarrh, the noise will gradually disappear—however not in all cases. I have seen patients who could hear perfectly well, and yet the continued noise in their heads made life a misery to them. A disease of the central organs of the ear being out of question, and the examination of the tympanum giving no clue whatever, we must take it for granted that the blood-circulation itself produces the noise, varying in its intensity. If the Fossa jugularis is enlarged, the blood pressing its way through the narrow opening of the sinus transversus will and must produce a rattling or hissing sound, increasing, as a rule, with a horizontal position of the body. I know of a lady sufferer, the noise in whose ears ceases at once by the compression of the vena jugularis.

In cases where a disease of the central parts of the ear has resulted in incurable deafness, and where, in addition, the tympanum is bulged inward, and where Menier's symptoms prevail, I do not hesitate (being a disciple of the Vienna school) to make the tenotomy of the musc. tens. tymp. The effect of the operation is generally quick and decisive; the noise, and that most alarming of Menier's symptoms: giddiness disappear, not to return again. The operation in itself is rather trifling.

The aurist in Sydney—and probably throughout Australia—will observe that, next to the chronic catarrh of the middle ear, the chronic purulent inflammation (tympanitis purulenta chronica) is most frequent. Happily the prognosis of the latter is more favourable than that of the former; although “one never can tell,” to use an expression of Professor Trötsch, of Würzburg, “to what a serious end a discharge of the ear may lead to,” we find that in far the most cases a cure can be effected. Also the hearing will improve if the juncture of the bones in the middle ear has not been effected by the mattering. I have no words severe enough to say against those medical men who advise the patient to allow the discharge of the ear to continue, fearing that its stoppage might produce a more serious internal ear-affliction, or believing that the discharge will stop on its own account. If these gentlemen would take the trouble to minutely examine the anatomical and osteological parts of the ear, to con-

sider the nearness of the meninges and of large blood-vessels to the seat of purulent inflammation, they certainly would hesitate to give such a pernicious advice. With the exception of the tympanum, all the neighbouring parts of the middle ear consist of life-important organs. I am certain that in the case of a boy of five years, F. M., who died in the beginning of last year with symptoms of “brain fever,” the cause may be attributed to purulent tympanitis, of which he suffered from his second year. The little patient was brought to me, all symptoms showing that the serum puris had extended to important parts, though meningitis had not then developed. The processus mastoideus was extremely painful on touch, the neighbouring parts swollen. Believing that it is always our duty to advise the adoption of extreme necessary measures in extreme cases, even if the result of such measures may be unpleasant to the adviser, I suggested the opening of the pars mastoid. for the evacuation of the pus, and in order to clear and disinfect the afflicted parts. I did not hesitate to pronounce the operation necessary, although dangerous. The parents, guided by the advice of the family physician, declined the operation, and only three weeks afterwards I heard of the death of the patient. Such a fatal result of otorrhœa is fortunately only a rare occurrence. Of 28 cases which have been under my treatment during the last year, all were benefited, except four who left before the treatment was finished.

Dr. A. Giles, of Adelaide, has published in the November issue of the *A.M.G.* some “Notes on Ear-practice,” giving his (favourable) experience of the boracic acid treatment in chronic suppurative inflammation of the middle ear. At the end of his paper the writer makes the remark, that several cases could not be benefited by borac. acid, and he therefore had to take recourse to other methods. Which methods? I am sorry Dr. Giles does not mention the same. The treatment of otorrhœa with boracic acid is rather old, and universally known, but it would be of importance to know the other methods in case borac. acid fails. I, myself, feel inclined to give the nitr. of silver treatment the preference to borac. acid. A 2 per cent. nitr. of silver lotion applied into the ear (after its being well cleaned and dried) for two minutes, and then neutralizing carefully with salt water, will often remove, in a very few days, the most obnoxious discharge of the ear, and this in cases where other remedies, including borac. acid, has been applied in vain. As a rule we will find that a thick and “sticky” discharge will be best benefited by borac. acid, while in a discharge of a more fluid nature the nitr. of silver treatment is more effective. When either of these two remedies

fail, I have found application of iodoform of good result. The inner ear must be well filled with iodoform, and not syringed until 24 hours afterwards. Several such applications will prepare the ear for an effective treatment with other remedies. (Also in a case of a large syphilitic ulcer on the soft palate—which ulcer, in connection with an ear-affliction, had developed within a few days and resisted the ordinary cauterisation and the inunction treatment.—I applied, at the suggestion of Dr. McLaurin, dry iodoform, after washing the ulcer with a weak sublimate lotion. The effect was, I may say, instantaneous. On the very next day, the ulceration had stopped, and the wound looked clean.) In chronic cases of otorrhœa we will find the perforation of the tympanum generally very large, often the whole of the drum has been destroyed. Where caries or necrosis exist, the treatment of course has to be principally directed to the removal of such, and if the suppuration goes together with scrofula or phthisis the constitutional disease has to be looked after in addition to the local treatment of the ear. But the local treatment must be applied all the same. It is always advisable not to confine the examination to the ear alone, but to ascertain also the condition of other organs, especially in regard to constitutional diseases. Of the mentioned 28 cases of chronic suppurative inflammation of the middle ear 7 were complicated with polyps, all of which protruding from the middle ear. After the removal of the polyps with the snare, the roots were carefully touched with acid chromic, which, for the purpose applied, is preferable to arg. nitr. Two of these cases I have still under treatment, as the polyps have the tendency to recidivate.

In regard to eye diseases, many interesting cases have come during the year under my observation, but none the nature of which has not been described previously in ophthalmiatric literature. We find that patients suffering from granulated lids predominate in the waiting room of the oculist. Where the disease has become complicated with pannus or other corneal affliction, it always takes some months before the patient can be properly discharged. Next to anomalies of refraction and accommodation, and next to "sandy blight," I have found, during the last twelve months, phlyctenular keratitis to form the most frequent complaint of eye-sufferers. These were mostly children under twelve years. Amongst the inter-ocular cases Iritis predominated, fortunately mostly of a mild nature. Glaucoma I diagnosed in six patients; in one case it seems to have been produced by the prolonged installation of atropine (iritis). I made iridectomy in three cases of glaucoma, with satisfactory result

(tension of the eyeball lessened in each case, the sight improved in two, and became stationary in one); two glaucoma patients left me, being disinclined to be operated on, and one patient I advised to seek comfort and care in the hospital. At one of the operations the wound healed with a large cystoid cicatrix. Eserin was used previous and after each operation.

All the cataract extractions (8) which I made in 1886 had a gratifying result. Seven were operated after Graefe's method, and one after Pagenstecher's (extraction of the lens with the capsula). One of these patients, a Mrs. R—, of Redfern, had five attacks of iritis afterwards (not caused by any healing or pressure of the iris in the wound), yet her sight is pretty fair. She reads with + 2 sn. 5 In all of these cases, except one, cocaine was used with a perfect anaesthetising effect. (I may mention here, that, since my publication on cocaine in the last January number of the *A.M.G.*, I have not again observed a case of cocaine poisoning, although cocaine has been applied very frequently by me.) Only at one cataract operation chloroform was given. It was this a case of a Mr. C— (64 years), from Taree, who, by the advice of Dr. Morris, placed himself under my care. The patient was of a rather nervous temperament, having lost, eight years ago, the left eye through an operation for cataract, and being blind in the remaining right eye for the last three years. However, the operation proved very successful, and the patient left four weeks afterwards, being able to read with + 2½ sn. 3, and ordinary newspaper print with + 3. This in spite of the following accident:—The patient's nurse, on the second day after the operation, while shaking the pillow under his head, struck accidentally and rather forcibly against the bandaged eye, producing instantly great pain. I arrived fifteen minutes afterwards, and, on examination, found the wound, which was made by the linear cut, open and the anterior chamber full of blood. The whole eyeball looked very irritated, and it was my opinion at that time that Panophthalmitis would be the consequence of the accident. I made a very firm pressing bandage, and renewing the same after 24 hours, found to my great delight that the wound had again closed, and that the blood was nearly absorbed. On the following day all danger was gone. It is the first time that I experienced or heard of a case where, shortly after an operation for cataract, the wound was completely forced open, and this without disastrous result to the organ.

One needle operation, for cataracta congenita, was performed on a small child. The cataract absorbed after about eight weeks, but a second operation, which was made to split the posterior

capsula of the lens, brought on a slight iritis and, consequently, a complete contraction of the iris. Atropine was of no avail. I have to wait now till the child is more advanced in years in order to perform iridectomy for artificial pupil.

Of other operations I may be allowed to mention 17 for strabismus, viz.:—15 strabismus convergens, and 2 strabismus divergens. Of the former 3 were operated after Critchet's method, the antagonistic muscle, after the tenotomy of the musc. rect. intern., being severed and placed more forward. This method is advisable in all cases where the degree of strabismus is more than 3", and where the sight of the squinting eye has become much weakened. Also two (one-sided) cases of glioma retinae I wish to mention, in both of which I found it necessary to perform the enucleatio bulbi. The tumours were too far advanced in growth to allow me to follow Prof. Horner's advice of first trying sclerotomy. The checking of the malignant disease is too uncertain by such an operation, and the disease itself too serious to be experimented on. One of the little sufferers (a son of Mr. G—, of Auburn) being weak and delicate, became, soon after the operation, hale and hearty. Of the other, Eddy L—, who came from Tasmania, I have not heard since.

Several other uncommon inter-ocular affections I had occasion to observe during the past year. Mr. T., of North Shore, came to me on the 6th July, complaining that while walking on the day previous, a sudden shade passed over the sight of the right eye, blinding the same partially. The ophthalmoscopic inspection showed the typical picture of an embolus of the lower-outer branch of the art. centralis retinae, obscuring the sight of the corresponding upper-inner region of the field of vision. A heart disease could not be detected, only strong palpitation was noticeable. Digitalis internally. Sight returned without any other treatment within a few days.

In September a Mr. W. came from Wellington, New Zealand, to consult me about his eyes. The ophthalmoscopic inspection showed nothing pathological, but the examination with the ophthalmometer proved patient to suffer from hemiopia, the lines between sight and blindness being in both eyes equally and sharply defined, the left eye being blind in the outer half and the right eye in the inner half. The place of the disease must therefore be in the left hemisphere of the brain; the nerve fibrils crossing in the chiasm from each side to both eyes. The only important statement in the history of the case was, that patient had a fall from horseback about three months previous to coming to me and about two months before

he noticed the defect of vision. He was for 15 days under my treatment (Heurteloup leeches on the temples, and potass of iod. internally) with apparently no result, and, being anxious to see his relations in England and consult some authority at home, he left for Europe.

More successful was the treatment of a case of acute neuritis retrobulbaris on a Mrs. L (sent to me, somewhat over a year, from Moss Vale by Dr. Madden). The patient, a woman of delicate structure, about 30 years old, became within two days perfectly blind, not being able to distinguish light and dark. The retinal picture was not much changed; the papilla slightly congested and the veins dilated but not tangled. A vigorous inunction treatment with mercurial ointment was at once instigated, and already on the third day her sight began to improve. Within three weeks the patient had so far recovered as to be able to go about. Her husband then took her back to Moss Vale, and I saw her six or seven months afterwards with her sight completely restored.

A similar occurrence of rather sudden blindness was that of a Mr. M., who was a passenger on board the ship *Abergeldie* (now lying in Sydney harbour). While the ship was passing the tropics, Mr. M. experienced giddiness and pain in the head, and found his sight rapidly declining. On his arrival in Sydney, in the beginning of December, the patient was sent to me by one of our leading medical practitioners. It was easy to detect a connection with a cerebral disease and the amaurosis. The last was complete. The papilla optica gave an exquisite picture of a checked disc (*stauungs-papille*). It is possible that a syphilitic infection, which Mr. M. had acquired six years ago, may have something to do with his present affliction. An application of the Heurteloup leech on the temples (removing from each side four drachms of blood only) relieved the pains in his head, but the mercurial inunction treatment did not (and hardly was expected to) do much good. I did not see patient again after his fourth visit to me, but I have heard since that his condition is unchanged. Symptoms of *tabes dorsalis* were clearly developed.

Some rather novel observations of colour-blindness in connection with, and as symptoms of, inter-ocular diseases I intend to publish on a future occasion. To-day I mentioned only a few instances (space forbids to give a detailed history of the cases) to prove that in Australia, as in the old country, diseases of similar nature may be observed by an aural and ophthalmic surgeon.

CASE OF INTESTINAL OBSTRUCTION.

READ BEFORE THE QUEENSLAND MEDICAL SOCIETY.

BY WILLIAM S. BYRNE, M.B., M. CH. UNIV.

DUB., HONORARY VISITING SURGEON, BRISBANE HOSPITAL.

ALEXANDER MORRISON, aged 32, van-driver, married, four children, no specific history, was always well up to October 18th, 1886. He had never suffered from any troublesome constipation in his life, and on the previous day he passed a fairly sized motion. However, on this Monday morning, which was 14 days before his death, he felt great pain over the whole abdomen. Tried several times to defæcate but failed. He then sent for a homeopathic practitioner, under whose treatment he remained until Friday, October 22nd. He told me he had had eight enemas since the Tuesday, four having been given on the previous day, Thursday, by the medical gentleman himself, without effect, some coming away immediately after injection and some remaining for two or three hours. He had suffered from continuous vomiting for two days, chiefly of frothy, bilious-looking stuff, for which he had been taking an effervescent mixture, but now he was having a drop of tincture of nux vomica every second hour. The enema, he said, caused him such intense pain and tenesmus that he could bear them no longer. His condition at the time of my visit was as follows:—He was lying in bed with his legs flexed, complaining of very great pain all over the abdomen, which could not be referred to any particular spot. He had had, immediately before my arrival, an attack of vomiting of frothy water and curdy milk; his face presented a peculiarly anxious and pained appearance, the tongue was of a dirty brownish-black colour, and coated with a thick fur. The pupils were normal, T. 97.4, P. 120. The abdomen was much swollen, tense and tympanitic all over, and there was no pain on pressure. Nothing abnormal was discovered by digital examination of the rectum. There was a peculiar appearance of the belly as if a string were tightly bound round it about the region of the umbilicus, which, at the time, I was at a loss to understand, but which I believe now to have been caused by the enormous distension of the transverse colon. He was micturating freely and the skin was acting well. I prescribed half-grain doses of opium in pill every hour for the first six hours, and every second hour after that time until I saw him again. Hot fomentations on the

abdomen, and the diet suitable in such cases completed the treatment then adopted. The next day on my arrival I found the patient reading the daily paper, expressing himself as being much better, the acute pain having left him. He still complained, however, of considerable soreness about the right iliac fossa, the tongue was much cleaner, the vomiting had ceased, he had had a good night's rest, but the abdominal swelling had but slightly decreased. On Sunday his condition remained much about the same, but on Sunday afternoon he vomited about two pints of fluid stercoaceous matter, after which he expressed himself as being much relieved, and certainly the tension of the belly was not by any means as great. The pain was now all referred to the right iliac region and round to the back, and there was distinct dulness as compared with the same part on the left side. Dr. Little visited the patient in consultation with me on Monday morning, and advised a continuance of the same line of treatment, substituting the hypodermic injection of morphia in place of the opium pill. The question of an abdominal section was entered into, but was rejected for the present, on account of the difficulty of coming to any accurate diagnosis, the patient looking so well and feeling himself so much better than he had done since the beginning of his illness. From this time things went on smoothly, the man remaining hopeful, cheerful, and comparatively out of pain, having occasional slight stercoaceous vomiting, until the following Thursday, the tenth day of his illness, when he again vomited a large quantity of faecal matter. I omitted to mention that on the ninth day he passed per anum a small semi-solid healthy-looking motion, the only one he passed during his illness, with the exception of a few pellets of hard faeces, and some mucus and blood, probably from the continued straining. Dr. Little again met me in consultation on Friday morning, and as there was no urgency in the symptoms, no sickness since the previous day, and the fact that the bowels had been even slightly opened, it was decided to continue the same treatment. I visited him twice daily, and on the following Monday morning he was no better and no worse. On that afternoon I was hurriedly sent for, and on my arrival found matters considerably altered for the worse. He had vomited half a basinful of stercoaceous matter, breathing frequent and difficult, pulse was 130, very anxious appearance of the face, and the extremities cold and clammy. I ordered his removal to the hospital at once, as any operative procedure was out of the question in the cottage where he lived. On his arrival at the hospital I found him evidently in a dying state, but determining to give him the chance of relieving the obstruction,

I proceeded to an abdominal section, but as I opened the cavity of the peritoneum the man expired.

Several questions are opened up by this case. First as to diagnosis:—This no doubt was a case of acute intestinal obstruction, but on what did the obstruction depend. Intussusception was probable, so were volvulus and internal hernia, stricture was doubtful, accumulation of faeces or lodgment of foreign bodies were against the history, compression by a tumour was improbable as the initial symptoms were most acute, and cancer in a man of thirty-two is rare. Narrowing down the probable causes, we come to three: intussusception, volvulus, or internal hernia. Next as to the location of the obstruction:—The pain was always referred to the right iliac fossa, there was distinct dulness over the seat of pain on the only two occasions when the tympanites had at all subsided, and there was only the uncomfortable feeling of distension in all other parts of the abdomen. I candidly confess that I expected to find an intussusception about the ileo cœcal valve, but Dr. Little, wiser perhaps, would not commit himself to any diagnosis. There was a question at our consultations of the propriety of passing a tube into the rectum, but at the time it was considered too risky and dangerous a procedure. Had I seen the man earlier possibly I should have passed a long tube as a means of diagnosis. At the *post mortem* examination I found quite an unexpected state of things. My diagnosis was completely at fault; there was nothing whatever wrong in the right iliac fossa, and I cannot account for the pain experienced by our patient, nor for the dulness on percussion. It was only after some searching with the abdomen laid freely open that I discovered the obstruction at the sigmoid flexure, about six or seven inches from the anus. Here I found a small hard lump, evidently scirrhus, round which the bowel wound, the calibre of which was greatly diminished, and when the specimen is seen you will understand how sudden obstruction occurred. The colon was bound down by extensive adhesions all round, but there was no evidence of any peritonitis whatever.

This, gentlemen, is to me a most instructive and interesting case. Here is a man, thirty-two years of age suffering from scirrhus of the rectum, evidently of some duration, without its causing any constipation, inconvenience, or pain, when suddenly acute and fatal obstruction is set up. Had it been possible to diagnose the exact seat of the obstruction and the disease itself, a colotomy might have afforded temporary relief. The specimen is here and I shall be pleased if you will examine it.

RHINITIS CHRONICA ATROPHICANS FÆTIDA.

READ BEFORE THE N.S.W. BRANCH B.M.A.
BY A. J. BRADY, L.R.C.S.I., L.K.Q.C.P.,
IREL., HON. SURGEON EAR, NOSE, AND
THROAT DR., SYDNEY HOSPITAL.

I PROPOSE to bring under your notice a rather common disease of the nose, which is often seen without its true pathology being recognized. It is apt to be classed simply as *ozæna*, which is only the name of its leading symptom. I refer to *Rhinitis Chronica Atrophicans Fætida*. A large number of cases of *ozæna* come under this head. I should say that the largest number of cases of *ozæna* are of this nature. It is far more common in the female than in the male sex, and usually begins about the age of 12 or 13 years. Its leading symptom is intense fœtor of the breath, which can often be perceived a yard off. When blowing the nose the patient occasionally brings away thick greenish-yellow fetid masses; there is sometimes severe frontal headache. The unfortunate sufferer is an object of disgust to every one whom she comes near, and she is rendered almost unfit for social life.

On examining the nose with the speculum and reflected light, it will be found to be lined with inspissated greenish-yellow masses, and when these are washed away, the nasal cavities will be seen to be abnormally roomy—usually the back of the pharynx can be seen, and the levator palati muscles when the patient swallows or phonates will be seen to rise. There is a true atrophy of the structures of the interior of the nose. The mucous membrane connective tissue, and even the bones of the turbinated bodies are atrophied. This condition is said by some to be preceded by a preliminary stage of hypertrophy. There is no ulceration, or disease of the bones.

The treatment which I employ is to thoroughly cleanse the nose twice a day with a good syringe and tepid water, in which I put a teaspoonful to the pint of the following detergent combination:—

Acid Salycil.	5.0
Soda Salycil.	30.0
Soda Bicarb.	30.0
Sodii Chlorid.	30.0

The nose is then sprayed out with Solution Hydrarg. Bichor., 1 in 3000. This often loosens further masses, which should be removed by syringing. I never use the nasal douche. It is inefficient on account of its want of force, and dangerous on account of its liability to cause acute otitis media. This is caused not, as some think, by too much force of the stream, by placing the vessel too high, but by the continuous stream fatiguing the muscles of the palate, which causes

the patient to swallow, and thus force the fluid into the middle ear. Some well known authorities say that this disease (although its leading symptom can always be removed while treatment is continued) is incurable. Recently several writers have denied this, and from my own experience I am inclined to agree with them. One thing is certain, namely, that the most objectionable feature of the disease can be kept completely in abeyance by treatment. These few notes are by no means intended to be a complete account of the subject, but merely to illustrate two cases which I will show to the meeting.

ORCHITIS IN A NEW-BORN CHILD.

By JOHN REID, M.A., M.D. et CH.M. ABERD.,
LATE OF PORT GERMEIN, SOUTH AUSTRALIA.

THE following case, if of traumatic is worth recording, if of syphilitic orchitis is noteworthy on account of its early appearance. The child, F. W. B., was brought to me on the 20th Nov., 1886. The mother says it always had a cold (snuffles), and that the woman in attendance at the birth noticed the left scrotum large, but said it was nothing. There were ulceration at the navel, slight bronchitis and thrush, with snuffles to a small extent. The scrotum on the affected side was congested at parts, boggy in feel, and very slightly, if at all, tender, as if containing fluid, opaque, and the testicle was enlarged uniformly to about $1\frac{1}{2}$ times the natural size. Under mercurial inunction, testicle and scrotum reached their natural size on the 25th. On the 26th, change of weather metamorphosed the bronchitis, which they refused to have treated, into bronchopneumonia (catarrhal pneumonia), and the child, at the age of 55 days, died at midnight from exhaustion. There was no autopsy.

The parents have been healthy, and the brothers and sisters, although pasty in appearance, have never exhibited signs of syphilis. The teeth are slightly notched in some of the children. A brother survived a severe attack of typhoid complicated with pneumonia, but uninfluenced by mercurials. Mother's brother (uncle) was treated by me for over a year for psoriasis of the leg, which yielded to anti-syphilitic treatment with chrysophanic acid locally applied. He denied ever having had connection, and his age is 23. Thus, if the disease is syphilitic, which I believe it to be from the uniformly enlarged hard testicle and the presence of snuffles, it must be the product of latent syphilis, just as that of its uncle's was. From the life of the uncle, J. A. F., I have reason to believe his statement, and also his assertion when he said he never suffered since childhood. There was no known cause of injury; the labour was natural.

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF QUEENSLAND.

THE regular monthly meeting was held on 14th December, 1886, at the Brisbane School of Arts. There were present Dr. Bancroft (in the chair), Drs. Mullen, Love, Hare, Tilston, Little, Taylor, McNeely, Hill, E. H. Byrne, W. S. Byrne, Neill, Lyons, Gibson, and the Secretary (Dr. Rendle).

The minutes of last meeting were read, amended and confirmed. Dr. Love was appointed scrutineer, a ballot taken, and the following elected members of the Society :—Drs. K. H. Byrne, F. W. E. Hare, E. G. R. Marks, A. C. Short. Candidates for membership were then nominated as follows :—Herbert Clatworthy, M.R.C.S., L.S.A. W. Grant Furley, M.R.C.P., M.R.C.S. Edin. J. Clement Ellison, M.B. Lond., M.R.C.S. Eng. W. Simpson Webb, M.R.C.S. Eng., L.R.C.P. Edin. Albert Dunlop, M.R.C.S. Edin., L.M. Francis M. Geoghegan, M.D., M.S., Q.U.I.

Members were asked to forward nominations for one vice-president, two auditors, and three trustees before the next meeting of Council.

The Secretary reported communications since last meeting, including letters and circulars from Dr. Poulton, of Adelaide, concerning the Intercolonial Medical Congress.

Dr. W. S. Byrne then read his paper on a case of intestinal obstruction, which will be found on page 99.

Dr. LITTLE had seen three similar cases in two years, and in all there was a striking absence of preliminary symptoms of cancer. In the present case operation was contra-indicated by the symptoms, and the condition found at *P.M.* showed that no good would have been effected by abdominal section.

Dr. NEILL, of Ipswich, considered the case of great interest as regards the differential diagnosis, and related a case of a man with stercoraceous vomiting and a history of hernia for which a truss had been worn; the hernial swelling had disappeared but the symptoms continued. The man was sent to the hospital but not operated on. He left and was again seen by Dr. Neill in consultation with Dr. Webb, the abdomen was opened and a portion of strangulated bowel found between the peritoneum and the abdominal wall; it was relieved, but too late to save life. If this man had been operated on early he might have recovered. In cases of doubt it was a duty to operate. He had seen a case operated on in Dresden and the patient lived four years.

Dr. GIBSON thought Dr. Byrne's case of interest, especially as the man might have lived if he had been operated on. The obstruction seemed to be due more to a volvulus than to the scirrhus; but if scirrhus was found it should be removed and the divided ends of bowel brought together. There was too much fear about opening the abdominal cavity. The risk was not great with antiseptic method.

Dr. LOVE said the diagnosis was very difficult, and in this case the pain in the right iliac fossa was misleading. He had seen a similar case in Edinburgh. An old man suffering from chronic dysentery was seized with stercoraceous vomiting; stricture, as a result of the chronic dysentery, was suspected and a bougie passed; there was sudden relief of the symptoms but copious bleeding followed, and at the *P.M.* a scirrhus growth was found surrounding the bowels.

Dr. TAYLOR thought the subject very interesting ; such cases often occur, and one is in doubt what to do. It was easy to say what ought to have been done, after making a *P.M.* Many cases recover without operation, and cases operated on die when they might have got well if left. He related a case where the obstruction was complete and after treatment with opium portions of bowel came away ; there was extreme tympanitis ; this was relieved by enemata, and faeces came away, and the patient got well. In cases of adults certainly an operation should not be lightly undertaken.

Dr. RENDLE said the difficulty was to make an accurate diagnosis ; the risk of operation was increased by delay, but was not very great when antiseptic precautions were taken. If he were ever in the condition of Dr. Byrne's patient and could place himself under the care of Mr. Lister, or some one able to carry out the precautions with equal care, he would far rather have an abdominal section performed to explore, and then, if obstruction of a permanent character existed, have colotomy performed than be treated in any other way.

Dr. HILL would not care to open the abdomen unless he felt pretty sure of finding and relieving the obstruction. Many cases of obstruction recovered ; in fact he was himself an example of recovery after obstruction lasting nine days, and should have been very unwilling for any one to have opened his abdominal cavity to search for the cause.

Dr. BANCROFT, referring to operation, thought success was often due to luck. In one case he saw with Dr. Mullen everything else was tried, and the patient died. On making a *P.M.* a piece of omentum was found adherent and a portion of bowel turned over the edge. If the abdominal cavity had been opened the obstruction could have been relieved with ease. In another case a large tube was tried but could not be passed ; a small tube was then passed and fluid injected, but none of it returned ; the belly was then opened, nothing was discovered ; it was closed up, and the patient died. At the *P.M.* a valve-like obstruction was found in the pelvis which allowed fluids to pass up but prevented their return. In this case colotomy would have given relief. The long tube often doubled up instead of passing on. In some cases the introduction of the hand might assist diagnosis. Another case where a hernia had apparently been reduced the symptoms continued, but, as peritonitis was present, no operation was done. After death the hernia was found to have been reduced, but a local peritonitis had caused death. In this case operation would have been of no use, and would probably have been blamed as cause of death.

Dr. BYRNE, in reply, said he was much gratified at the amount of discussion. He confessed that he had no idea of what would be found at the *P.M.* The abdomen was so distended that it was impossible to ascertain anything by touch, but after the vomiting there was some diminution in the size, and then he detected dulness in the right iliac fossa. If an abdominal section had been performed it was most probable that nothing would have been found, because at the *P.M.*, with an incision of four inches, nothing could be felt, and on extending the incision, still nothing. It was only after making a free crucial incision that the seat of obstruction was detected. One very marked feature in the case was the constricted appearance around the umbilical region as if tied around, and he thought this indicated obstruction below the transverse colon. The long tube often doubled up and was of no use, and in some cases it might be made to perforate the gut.

Dr. TILSTON related a case where this constriction was very marked and led him to tap the distended bowel, but without benefit. Opium was then given and

the case recovered. He thought one ought not to be too rash in operating.

SOUTH AUSTRALIAN BRANCH B.M.A.

MONTHLY MEETING,

Held at the Adelaide Hospital, Oct. 26th, 1886.

PRESENT :—The President (Dr. Verco), Prof. Watson, Drs. Cawley, Lendon, Poulton, Stewart, Stirling, Wigg ; Messrs. Ollendening, A. A. Hamilton, and the Hon. Sec. (Mr. Cleland).

PATHOLOGICAL SPECIMENS.

Professor Watson showed numerous interesting specimens of repair in bones after fracture. Also a case of senile eccentric absorption of all the bones of the body, whereby they had become so thin as to be quite translucent.

Dr. Verco exhibited the left lung of an old woman, in the lower lobe of which was a large cavity, the seat of hydatid cysts. This had opened into the pleura, where lay the two collapsed cysts. The pleural walls were much thickened, and the pleural cavity contained air, and some pus. The excavation in the lung was shown to have thickened walls, but these were not complete, for it communicated freely by several apertures with the bronchial tuba. This was referred to as an explanation of the two catastrophes which may happen even in an aspiration of a pulmonary hydatid, first, a pneumothorax ; and second, the coughing up of the hydatid fluid in greater quantities than it is drawn off by the aspirator, and at the same time.

Dr. E. C. Stirling then read the "Notes of a Case of Total Extirpation of the Uterus by the Vagina for Carcinoma, with Recovery," which will be found on page 89.

The PRESIDENT thanked Dr. Stirling for his paper, and congratulated him on the success of the operation, and with the more pleasure as it had been undertaken at his (the President's) instigation. One point had been settled : the operation was not necessarily fatal, and though the risks were great, a physician could justifiably advise it. Temporizing treatment by scraping, and, when this was no longer useful, palliation of symptoms were so unsatisfactory, that one looked anxiously for a more radical operation. What we require now is unimpeachable testimony as to the frequency of recurrence after the operation, the date of its return, and the estimated prolongation of life. If only a very small proportion remain permanently free the risk will be justifiable ; and even though there should be none or almost none in whom the disease does not re-appear, yet if it can be shown that life is probably lengthened by two or three years, as is the case in cancer of the breast, we could still advise operation. Dr. Stirling's case emphasizes the need of vaginal examination in cases of vaginal discharge continuing after delivery. These are sometimes diagnosed without examination as chronic sub-involution. They may be cancer. The only other case I have had extirpated developed the cauliflower excrescence only a few weeks after confinement. And as extirpation to be of use should be early, the earlier the cancer is detected the better.

Dr. J. C. Verco read a paper on "Multiform Skin Eruption" ; Dr. J. T. Mitchell the notes of a "Case of Accidental Vaccinia" ; and Dr. L. W. Bickle on a "Case of Renal Calculus" and "Curious Foreign Body in Ear causing Deafness," which, if possible, will be published in next issue of the *A.M.G.*

INTERCOLONIAL MEDICAL CONGRESS.

MEETING OF SUBSCRIBERS IN SOUTH AUSTRALIA TO INTERCOLONIAL MEDICAL CONGRESS, ADELAIDE, 1887.

Held on the 11th December, 1886, at the Adelaide Hospital.

Present :—Dr. Verco (Chairman of Provisional Committee) in the chair, Messrs. Clindening, Curtis, Aitken, John Astles, Anstey Giles, Horneck, A. A. Hamilton, Sanderson Lloyd, McGowan, Hayward, the Hon. Allan Campbell, M.L.C.; Drs. H. E. Astles, Gardner, Görger, Lendon, Mitchell, Symons, Robert Stewart, A. E. Wigg, Niesche, and Dr. Poulton (hon. sec. of the Provisional Committee). Seven gentlemen who were unable to attend were represented by proxy.

The Chairman made a short statement, and the Hon. Sec. read the Progress Report of the Provisional Committee, as follows :—

Progress Report of the Provisional Committee appointed by the South Australian Branch of the British Medical Association, to take steps for the establishment of an Intercolonial Medical Congress in Adelaide during the jubilee year, 1887.

"The Committee have the honour to report that they were appointed at the Annual Meeting of the South Australian Branch of the British Medical Association held in June, 1886; that at the Monthly Meeting of that Association Branch held on August 26th, Dr. Poulton was elected Hon. Secretary, and that they have added to their number Professor Watson, M.D.

"Early in September a preliminary announcement was issued, and posted to the address of every known and accredited member of the profession in the Australasian and neighbouring colonies, with a special appeal to members of the profession in South Australia not members of the Local Branch of the British Medical Association.

"Notice of the proposed Congress has been sent to the Australian Medical Journals, and the leading British, French and Indian Medical Journals; and letters enclosing the preliminary announcement have been sent to the Presidents and Chairmen of each Medical Society in Australasia.

"Through the kind offices of the Exhibition Committee representations have been made to the Agent-General and Sir Samuel Davenport, pointing out the desirability of securing the display of Scientific and Surgical Apparatus and Appliances at the Exhibition.

"The University Council has generously granted the use of such rooms as the Congress may require during the August-September Vacation, 1887.

"In October, the Provisional Committee made a report of progress to the South Australian Branch of the British Medical Association which was adopted, and the Committee were instructed to proceed with their labours, and to make arrangements for placing the matter fully in the hands of the profession throughout the colony.

"On November 16th a circular was issued inviting the co-operation of all practitioners and the enrolment of members, asking nominations to the office of President, and also announcing a General Meeting in December for the election of President, and the direction of further proceedings.

"In response to this circular letter sixty members of the profession have given in their adherence to the project, also the Secretary of the Victorian Medical Society, the Secretary of the Medical Society of Queensland, the President of the Newcastle Medical Society, the Canterbury Branch of the New Zealand

Medical Association, and also from leading members of other societies.

"The Editors of the Australasian Medical Gazette and the Australian Medical Journal have each expressed their cordial approval in their respective monthlies, and intimate, by letters, their intention of continuing to forward the movement and of attending the Congress in person.

"The Provisional Committee propose that the Congress be held during the August-September Vacation of the Australian Universities, and last not more than six (6) days; that the Governors of the Australasian Colonies be asked to become Patrons of the Congress, thus following the precedent of the International Congress held at London in 1881—which was under Royal patronage—and ensuring a more widespread interest in the meetings.

"They would invite the Presidents and Chairmen of the various Medical Societies in Australasia to become Vice-Presidents of the Congress.

"They would suggest the election by this meeting of a President, and an Executive Committee, with full power to act for and on behalf of the subscribers in arranging the further organization and working of the Congress.

"In addition to the Executive Committee a Reception Committee is desirable, and Dr. Stirling who has been nominated by several members as President, and has withdrawn in favour of Dr. Verco, expresses his willingness to take that office. It will rest with this meeting to determine the election of the Reception Committee, the Honorary Secretary, and the Honorary Treasurer.

"You are invited to fix a time for any further General Meetings before the Congress meets, and the Committee suggests that it may be desirable to hold one next June for the reception of a final report from the Executive Committee.

"The Provisional Committee now resign their trust into your hands."

The Report was adopted on the motion of Mr. Curtis, seconded by the Hon. Allan Campbell.

There were seven members nominated for the office of President, some of whom declined to act, and the rest had expressed their desire to retire in favour of Dr. Verco.

Mr. Curtis proposed and Dr. Görger seconded, "That Dr. Verco be President of the Intercolonial Congress of 1887." Carried unanimously.

Mr. Curtis proposed and Dr. Görger seconded the motion "That Dr. B. Poulton be elected Honorary Secretary of the Congress." Carried.

It was carried on the motion of Dr. A. A. Hamilton "That the number of the Executive Committee, exclusive of the President and Honorary Secretary, be twenty (20)."

A ballot was taken, resulting in the election of Drs. Gardner, Way, Thomas, Watson, Whittell, Stirling, Symons, Görger, Lendon, Paterson, Cleland, Stewart, Giles, J. A. G. Hamilton, Messrs. Hayward, Clindening, Corbin, Jay, and Toll, and the Hon. John Cockburn, M.D., Minister of Education.

Mr. Hayward was elected Hon. Treasurer.

The Committee were empowered to add to their number, and were given full power to make all arrangements with reference to the work and conduct of the Congress, and were instructed to report to the subscribers at a General Meeting to be held in June, 1887.

The questions of Vice-Regal Patronage, and the choice of Vice-Presidents were with all other matters placed in the hands of the Committee.

The meeting then adjourned at 10.30 p.m.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JANUARY 15, 1887.

EDITORIALS.

OUTBREAK OF SMALLPOX ON THE NORTH GERMAN LLOYD S.S. "PREUSSEN."

WE again have smallpox in Australia, and though for the present it is confined to the passengers and crew of this ship, who are now, with one exception, in quarantine, it is impossible to say whether it will be kept within these limits. One of the engineers escaped from the vessel in Melbourne, and is supposed to be at large in that city. He certainly is so, unless, as has been asserted, he lost his life in attempting to swim ashore. We are of opinion that the probabilities are that he successfully made the land. It has been stated that the engineers' department was especially exposed to contagion from the first patient who developed the disease at sea on Dec. 5th. If this is the case, the absconder is likely to prove an active source of infection, if not through himself, through his clothes, a portion of which he is supposed to have taken with him.

Immediately on being informed that the "Preussen" had arrived at Albany with a man suffering from smallpox on board, the Health authorities in Sydney wired to those in Western Australia suggesting that the patient should be removed and the ship disinfected. The reply to this was that as the other colonies had not recognised the principles of Federal Quarantine, they were not prepared to act alone. Similar hesitation to accept responsibility took place in Adelaide, and the unfortunate passengers were kept on board the plague-stricken ship until they arrived at their destination, the result being the presence of the disease in three colonies, Sydney having the largest share, there having been upwards of 70 cases developed to the time of writing, with 6 deaths. The time at which the disease showed

itself renders it reasonable to suppose that, had Federal Quarantine been in existence, no person would have been infected beyond the first patient, who would have been removed at Albany.

We can only again do what we have continuously been doing, that is to express our opinion that the neglect of the various Australian governments to give practical effect to the recommendations as to Federal Quarantine, made by the Australasian Sanitary Conference of 1884, is a disgrace to humanity and responsible government.

We here republish the interim report of Dr. MacLaurin, the president of the Board of Health in Sydney, which will place our readers in full possession of the facts :—

"Although from the difficulty of receiving detailed communications from the Quarantine Station it is impossible to lay before the Board a complete account of all the features of this outbreak so far as it has gone, still it has been deemed advisable to bring forward, in the shape of an interim report, some of the facts which seem to have a very practical bearing upon the relations between this and the other Colonies.

"The S.S. 'Preussen,' 4000 tons, Captain Pohle, from Bremen, *via* Southampton, arrived at Albany on the 15th of December, with a case of smallpox on board. It was believed that the infection was taken at Port Said; the initial fever appeared on the 5th of December, and the rash on the 8th. Immediately on the appearance of fever the patient was isolated in a second-class cabin, with two of the crew to attend on him, so that he might be removed from contact with steerage passengers. On the 9th about 130 passengers are said to have been vaccinated by the surgeon of the ship.

"On the evening of the 15th, on receipt of a telegram from the Health Officer at Albany, announcing the arrival of the vessel at that port, the president telegraphed to him inquiring further particulars and what he proposed to do. In reply the following telegram was received :—

"We propose to send ship on her way after giving her coal and water; she is anchored in our outer harbour in strict quarantine; I find she has about 600 people on board; only one case of smallpox, eight days old; passengers both for Adelaide and Melbourne; most likely she will get to Sydney; how about Federal quarantine?"

"The president then telegraphed the following suggestion :—

"Message 16th received; if ship not started would suggest you land the patient and disinfect ship, following the principles of Federal quarantine."

"To this the Health Officer at Albany replied :—

"Thoroughly approve of suggestion, but no means; the other Colonies have not recognised the principles of Federal quarantine, consequently we are not prepared to act alone."

"Finding that the authorities at Albany declined to remove the source of infection from the ship, the president caused the following telegram to be sent to the Central Board of Health at Adelaide :—

"This Board suggests that patient from S.S. 'Preussen' be landed at Adelaide, and ship thoroughly disinfected by health authorities."

"To this the following reply was received :—

"Board's solicitors advise no power to compel captain to disinfect ship."

"Being desirous of leaving no stone unturned to prevent the spread of disease, the president at once communicated with agent of 'Preussen,' and recommended them to instruct their correspondents at Adelaide to give Health Authorities of that port full authority to deal with the disinfection of the ship. This they readily consented to do, and they prepared a telegram to that effect in this office, which was despatched without delay. In order that there should be no mistake, the president also directed the accompanying telegram to be sent to the Board of Health at Adelaide :—

"Am informed agents of 'Preussen' will authorize your Board to disinfect ship."

"To this telegram the following reply was received :—

"Doctor will board ship on arrival, order disinfection of part occupied by patient, remove patient and Adelaide passengers, and go with them into quarantine; disinfection of ship occupied by passengers over whom we have no authority untrustworthy."

"The ship arrived at Adelaide on the 20th December, the patient being too ill to be landed; he died almost immediately after arrival. The body was not landed but afterwards buried at sea. The two attendants and twenty-seven Adelaide passengers were landed at Adelaide Quarantine Station, the South Australian cargo was discharged and the patient's clothes were burned.

"The ship arrived at Melbourne on 22nd December, where all the crew were vaccinated. Two hundred and sixty passengers were landed at the Quarantine Station, Point Nepean, the cargo and mails were discharged, and George von Rueti, an assistant engineer, succeeded in deserting.

"The ship left Melbourne for Sydney at 4.30 p.m. on December 24, and arrived in Spring Cove at 1.40 p.m. on the 26th, there being apparently no infectious sickness on board on her arrival.

"On the 27th December disease began to show itself both in Sydney and in Adelaide, one man being sent to the 'Faraway' with a papular eruption, and one woman at the Quarantine Station, Adelaide, having developed smallpox.

"From that date to the present no day has passed without the occurrence of several cases of smallpox at North Head Station, and we have, on the evening of the 3rd of January, fifty well-marked cases of smallpox under treatment, with twenty-seven cases in isolation, besides one patient, who died from smallpox at 4 o'clock this morning.

"Although the incubation period of smallpox may sometimes be considerably prolonged, as is well known in the experience of this Board, yet it is agreed by most authorities that the most common period is about twelve days.

"On examination of the facts above detailed it will be seen that from the date of the arrival of the ship at Albany, to the appearance of the first cases of smallpox in this port and in Adelaide, a period of exactly 12 days elapsed, a duration which coincides with singular accuracy with the most usual incubation period of smallpox.

"The vast majority of the cases which have appeared here have shewn themselves after a period of considerably more than 12 days from the arrival of the ship at Albany.

"It would not seem unreasonable to infer from this statement that the means taken to isolate the patient on the ship before her arrival at Albany had been on

the whole fairly efficient; that prior to her arrival at that port infection had scarcely, if at all, spread to the other passengers, and that the patients who are now suffering from smallpox owe their illness for the most part to infection received after the fifteenth.

"Had the authorities at Albany, immediately on the ship's arrival, removed the smallpox patient to the shore, and suitably disinfected the ship, it is reasonable to conclude that the terrible amount of suffering and danger which has since ensued might have been almost, if not altogether, averted.

"Apart from any consideration of the advisability of adopting the principles of Federal Quarantine, as laid down by the Intercolonial Sanitary Conference of 1884, common humanity demands that when a ship with infectious disease on board touches at any port the authorities of such port should afford her the very obvious assistance of removing, if possible, the source of infection from her midst.

"H. N. MACLAURIN, M.D., President.

"Sydney, 3rd January, 1887."

THE DAIRIES SUPERVISION ACT IN NEW SOUTH WALES.

We would especially call the attention of our readers in New South Wales to the recently enacted Dairies Supervision Act, which came into force in the metropolitan police district on January 1st. We republish the 7th section, which relates to the action to be taken by the medical practitioner in attendance on any person residing on premises licensed under this Act suffering from cholera, enteric fever, smallpox, scarlet fever, diphtheria, measles, or syphilis, which the Governor in Council has declared to be contagious diseases under its provisions :—

"On the appearance of any case of infectious disease in any dairy premises or milk store within a district the householder or occupier or if there be no such householder or occupier the owner of such premises or store and also the medical practitioner attending the case shall immediately report in writing such case to the proper authorities in manner following that is to say if the case occur within the City of Sydney then the reports of the case shall be delivered to the officer in charge at the nearest or any police station within such district or to the Secretary of the Board of Health and if the case occur beyond the City of Sydney then the reports shall be delivered to the nearest officer of Police Clerk of Petty Sessions or to the Government Medical Officer of the district within which the case has occurred." (Every person who fails to make such immediate report will be liable to a penalty not exceeding £20.)

THE OVERCROWDING OF THE PROFESSION IN THE AUSTRALASIAN COLONIES.

We so frequently receive communications from members of the profession residing in all parts of the world asking for information as to the prospect which they would have of successful practice in these colonies, and as it has become the custom of the European and American Journals to refer gentlemen making similar enquiries of them to us for information, we think it will not be ill-timed if we take the present opportunity of giving a general answer to such enquirers, by a review of the situation.

The number of medical practitioners arriving in these colonies each year is very much in excess of the proportion it should bear to the increase in the population, when a due prospect of success is considered. Some of them are natives of Australia who have gone home to study, others gentlemen who have connection more or less intimate with persons of influence here, whilst a number are complete strangers to our country and people, and of course have to make their way in the face of the great handicap of being entirely unknown. The abuses of the system of Benefit Societies are rampant in our larger cities, and it is within our own knowledge that the principals in large firms of manufacturers and shipowners who have risen in the world, whose incomes are to be reckoned by thousands a year, still belong to societies which they joined in their days of early struggle, and continue to avail themselves of the services of the doctor of their sick club when any of their family are ill, for the paltry payment which they make of a pound to thirty shillings per annum. Some of them express indignation when it is suggested that they are hardly "doing as they would be done by" when with their wealth they avail themselves of such petty privileges. Strangers to the colonies who think of leaving the older countries to settle here, should remember that they may "jump from the frying-pan into the fire," and that they will have to enter into brisk competition with practitioners who have been long settled here, in addition to others who come out because they have more or less intimate connection with people of local influence in the place where they intend to make their abode.

It must not be forgotten that what may be said to be an undue proportion of the most intelligent youth of our population are yearly taking up medicine as a profession, and that in addition to the students at the medical schools of Melbourne, Sydney, Adelaide, and Otago, N.Z., a great many young men leave these shores for study and to

obtain qualifications in Europe and America, almost invariably with the intention of returning to their birthplace to practise. As an exemplification of the rapid increase in the numbers of medical men, we may give as an example one suburb of one of our larger cities. Five years since in that district there were but three medical men, at the present time in the same district there are fourteen practitioners; the population has no doubt largely increased, but in nothing like a due proportion. In addition, in New South Wales, quacks are rampant and can practise without the control of any law restricting their doings. A first-class man will, of course, succeed here after he has made a reputation, as he would do almost everywhere, but the prospect is not sufficiently good to justify us in refraining from advising unknown men against rashly rushing out here on mere chance. Appointments are not so easily obtained as formerly, and for every vacancy a perfect rush is made by numbers of eligible men—in one instance lately, upwards of sixty making application.

THE NEW POISONS ACT OF TASMANIA.

The Parliament of Tasmania has followed the example of the other colonies when passing an Act to regulate the sale of poisons, a little too closely, for the absurdities are taken equally with the more valuable provisions. For instance, the first schedule is divided into two portions called the first and second parts, the poisons in each being of an equally deadly character, those in the one being as likely to be used for a felonious purpose as those in the other. It is provided, in section five, that the purchaser of poisons enumerated in part one shall give very full particulars as to his name, address, and the purposes for which he requires the drug, which are to be entered by the vendor in a book to be kept for the purpose; and it provides in section eight, that no person shall sell any poison enumerated in this part to any individual under the age of eighteen who is unknown to the vendor unless in the presence of a witness who is acquainted with both parties. These are very proper provisions, but why they should apply to cyanide of potassium and the poisons in part one of the schedule, and not to laudanum, opium, phosphorus, and the other equally deadly drugs which are included in part two, is, we must acknowledge, past our comprehension. In fact, part two is not mentioned in the Act, and apparently the drugs included in it are only dealt with by clause six, which relates to the sale of all poisons without distinction. As an interesting conundrum we republish the

schedule, that our readers may make the attempt to elucidate the mystery which surrounds the object of the Tasmanian Legislature in making such distinction between the poisons included in the two parts.

LIST OF POISONS.—*First Part:* Cyanide of potassium and all metallic cyanides, arsenic and its preparations, prussic acid and its preparations, strychnine and its preparations, savin and its oil, ergot of rye and its preparations, chloral hydrate, all poisonous vegetable alkaloids and their salts, aconite and its preparations, tartar emetic, corrosive sublimate, cantharides. *Second Part:* Oxalic acid, chloroform, belladonna and its preparations, laudanum, opium and all preparations of opium or of poppies, arsenical preparations except green and other coloured paints and pigments, essential oil of almonds unless deprived of its prussic acid, aquafortis, oil of vitriol, phosphorus, carbolic acid.

The value of the Act depends entirely on its administration, and this, if not better than in the other colonies, will be wretchedly bad and of but little practical use for the prevention of accident or crime. We think no law of this kind will properly fulfil its supposed object until it so regulates the sale of proprietary medicines as to necessitate the publication of the formula from which each is prepared with every package of the preparation.

LETTERS TO THE EDITOR.

TRAVELLING MEDICAL REFEREES.

(To the Editor of the A.M. Gazette.)

SIR,—Having by painful experience gained the knowledge which enables me to write this letter, I feel I should do less than my duty did I not place the information before my professional brethren that they may not be entrapped into similar mistakes through ignorance. The position of "Travelling Medical Referee" in these colonies is, without doubt, the most degrading appointment which medical men can hold. For the greater part of their time they are associated with agents whose lack of education is only equalled by their want of good manners. I have heard of their being requested by the agent to help grooming the horses, and should any complaint be made at head-quarters, the agent is never at fault, and is certain of sympathy. Frequently a "new chum medico" finds himself in some back block township far away from any signs of civilization, with an agent who combines "spirit" and religious mania; or suffering from excessive economy leaves him behind, and a heavy score as well. He is expected to drink with every "Tom, Dick, and Harry" or be grossly insulted; he must be ready for work from early morn till midnight, and after travelling for hours under a tropical sun finds himself at some bush hotel, where at night the noble family of the "Norfolk Howards" make a feast off his manly form to the warbling of the happy mosquito. How he dreams of home and wishes himself there, but he has yet much more colonial experience to undergo

before he becomes thoroughly seasoned. In his travels he may even get beyond the sportive "pub" and find himself in a bark mansion of two rooms where true happiness reigns. He must not be particular as to the cleanliness of the linen, as we have it on reliable authority that the sheets may be changed once a month. He will find most frequently in his bush journeying the food and accommodation a disgrace to civilization.

Now, what is the remuneration offered to a man who by education and profession is a gentleman for these hardships? In some assurance societies he gets a fee of one guinea for each case examined and two guineas per week travelling allowance; in others a guarantee of six guineas a week and no allowance. But I know one munificent office which employs a medical man to walk the streets of a country town in the company of its canvasser for the modest sum of four guineas weekly. I know of another referee who in the suburbs does a house to house visitation with the agent for a similar sum. In these cases the referees must have as high a sense of professional honor as the companies of their services.

The Boards of Management of assurance societies take good care to pay themselves well. The general manager of one small company which could only exist in New South Wales (there being no Insurance Act here) receives £1,200 a year for his gigantic efforts to shew the poor how to make a *future* provision, whilst he himself prefers the *present*. When a manager in receipt of £2,000 a year requires a rest he is sent to England at the expense of the assured, but should the unfortunate referee do no business, or get ill in its pursuit, he must rest at his own expense.

I would impress upon our medical brethren the necessity of being better paid and more respected by these societies, or else of refusing to work for them, since their success depends greatly upon the judgment and care of their medical referees.

Yours, &c.,

M.R.C.S.E.

THE MEDICAL EXAMINATION OF PERSONS ARRESTED ON SUSPICION.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—On December 11th, I was requested by the coroner to accompany the police fourteen miles into the bush to assist the investigation of a suspected case of infanticide. We found a newly-born infant in a water-closet, upon which in due course I made a *P.M.* examination. I was then requested to proceed to the house where the putative mother resided, and examine her. This I said I would do, "*if she consented to such examination.*" The constable turned rather sharply to me saying, that as he intended to arrest the girl on suspicion, and she would then be his prisoner, I "*must examine her whether she consented or not.*" As it happened, the girl was not to be found.

On returning to the township I spoke to the coroner on the subject, whereupon he also said that when a woman is arrested on suspicion of infanticide, the doctor must examine her, with or without her consent. I told him that I declined to examine in this or any similar case without the consent of the accused person.

Eventually the mother brought the girl in, and she was admitted to the local hospital for badly ruptured perineum, and the whole matter arranged itself.

Now, Sir, what I wish, is to know whether I acted rightly or wrongly as regards the matter of examination without consent? The coroner would have none of "Taylor's Jurisprudence," saying that N.S.W. laws were

different to English, and that he never heard of Taylor, except on "Poisons."

As a similar experience may happen again to myself, or to some other country medico, you would do a great favour by settling the matter by a brief reply in your next issue.

I beg to remain, Sir,

Yours truly,

LL. D. PARRY.

Hill End, N.S.W., Dec. 18, 1886.

[A medical man is not justified in examining any person arrested on suspicion without his or her consent, and should he attempt to do so would commit an assault, for which he would be liable to the ordinary legal penalties. The police officer or magistrate at whose instance he acted, we are of opinion, would also be liable as accessory to the assault.

The conduct of the coroner and constable, as described by our correspondent, is far too common on the part of individuals placed by unpropitious accident in circumstances which enable them to act upon their very peculiar ideas as to their power in such cases. That the coroner was unacquainted and unwilling to act in accordance with the course of practice laid down in "Taylor's Medical Jurisprudence" is in no way surprising, and it is a matter for congratulation that he has heard of "Taylor on Poisons."—ED. A.M.G.]

TINCTURE OF ACONITE.

(To the Editor of the A. M. Gazette.)

SIR,—Will any of the readers of the *Gazette* kindly inform me if tincture of aconite, given *hourly* in one minim doses for more than 36 hours to a child three years old, would produce dangerous symptoms, or prove fatal?

I am, sir,

Your obedient servant,

TAS.

ECZEMA SQUAMOSUM.

(To the Editor of the A. M. Gazette.)

SIR,—I have a very chronic case of eczema squamosum, in a miner from Croydon, aged about 50 years. He is like a serpent casting his skin; every morning there is a quarter of a dustpan full. I have tried tonics, &c., also arsenic, and numerous external applications, and should feel much obliged if you could get me some further advice from any of your numerous readers, as the case does not appear to improve, although the first fortnight it appeared to do so. I may say that he is covered from head to foot with it, and his general health good, although subject to rheumatism.

Yours, &c.,

SUBSCRIBER.

Northern Queensland, December 1, 1886.

[DR. A. HOFF, of Sydney, a specialist for diseases of the skin, has favoured us with his opinion on this case, as follows:—"My treatment for this obstinate case of eczema squamosum would be to rub the skin well off by means of a coarse flannel moistened with spiritus saponatus kalinus, the formula for which is:—*R. Sap. moll. parts ij; spir. rectif. part j; solve, filtra, adde spirit lavand. ad libit.* Wash off the solution with clean water, and rub on a fatty substance; the best is cod liver oil, or, if this be objectionable on account of the smell, pure olive oil. This procedure has to be repeated morning and night, for it may be a couple of weeks until the skin is free from scales; then apply tar. This latter remedy I would use mixed with diachylon ointment 1 part tar to 20 parts of ointment,

gradually increasing to equal parts of tar or even more. Tar should always be tried on small patches first, in order to find out whether it increases the irritation, in which case its application has to be postponed. Once or twice a week a tepid bath should be given. Such internal remedies as the general state of health may require must be used at the commencement when there is much irritation; acetate of potash, internally, gives great relief. Arsenic is advisable in obstinate cases. But whatever treatment is resorted to in cases of chronic eczema, the greatest perseverance is indispensable to secure a successful result. For the last few months I have used the new fat 'Lanoline,' as a substitute for the ordinary fat in skin diseases, and, although my supply of 'Lanoline' was rather small, and therefore my experience limited, I am sure it will prove most valuable for our hot climate, as it never gets rancid. If 'Lanoline' should already be available in Northern Queensland, I would recommend it instead of any other fat.—A. HOFF, M.D., Sydney, December, 1886."]

REVIEW.

Handbook of Diseases of the Ear. By URBAN PRITCHARD, M.D. Edin., F.R.C.S. Eng. London: H. K. Lewis, 1886.

Otology now holds a deservedly high place among the specialties, and of late years so many works have appeared on the ear and its diseases, suitable for the everyday practitioner, that it is astonishing so much darkness still exists about so important a subject.

Dr. Pritchard's handbook is eminently readable, succinct, clear and practicable. With the exception, perhaps, of Huxley's, which is for the general reader, the author's description of the Anatomy and Physiology of the Ear is the neatest *multum in parvo* with which we are acquainted—a masterpiece of clearness and shortness of description. Many years ago we read Dr. Pritchard's abstruse, physiological MS. on the rods of Corti; we now delight in the simple, clear language in which he gives the lessons of his experience. The chapters are all good, but those on Acute Suppurative and Chronic Catarrh, and Meniere's Disease merit special attention. The author's account of the mode in which disease extends from the ear to the substance of the brain strikes us as highly satisfactory, but when we consider the extraordinary success which has followed cerebral surgery in the hands of Victor Horsley, Macewen, Roberts of Philadelphia, and others, we hope "no treatment can be of any avail" in cerebral abscess may prove "a nut to be cracked." There is a most interesting chapter on the education of so-called deaf mutes, and a hope expressed, in which we sincerely join, that we shall have State aid given so that no one, however poor or humble, will be shut out from the advantages of the most valuable mode of education—pure oral system, which gives him

communication with his fellows. There is an excellent appendix of formulæ, which will prove a great help to practitioners in selecting appropriate remedies.

THE MONTH.

NEW SOUTH WALES.

THE Hon. Dr. Mackellar, the representative of the Government in the Upper House, has accepted the vacant portfolio of Minister of Mines.

THE Newcastle Sanitary Association held a meeting on December 22. Dr. C. W. Morgan was in charge of a motion that the Governor be memorialised to put in force a recommendation of the President of the Board of Health, by existing power conferred upon him by the Nuisance Prevention Act, and be empowered by the Colonial Secretary to take the sanitary affairs of the city out of the hands of the council. This, after a long discussion, was withdrawn, in the hope that a motion of Alderman Dr. John Harris, in council, would have a good effect.

THE annual meeting of the subscribers of the Nurses Home and Training School, took place at the Home, Phillip-street, Sydney, on December 15, the Hon. Sir Alfred Stephen, G.C.M.G., presiding. From the annual report, presented to the meeting, we take the following :—"The committee have great satisfaction in stating that the work done by the institution again shows large increase over that of the preceding year, the finances are in a satisfactory condition, and the medical profession and the general public have again expressed most unmistakably their appreciation of the usefulness of the Home. The number of nurses has again increased from 15 to 24, for while 3 left the Home for various reasons, 12 joined the staff during the year, including two who have been specially trained for the Home, as probationers at the Sydney Hospital. Among the new appointments was Miss Harriet Munro, the present matron, who received her training in St. Bartholomew's Hospital, London, and has had valuable experience as matron in the Sick Poor and Private Nursing Institution, Manchester. Miss Munro was appointed matron in June, immediately on her arrival in Sydney; Miss Parker, who had held the position for three years, and had done much useful work for the Home, having resigned, and left for England a few weeks before. It may be advisable to state that every nurse on the staff has received a thorough training in a British or colonial hospital or training institution, and has since been in constant practice in hospital or private nursing. The number of cases of sickness attended during the year was 320."

MR. W. M. HAMLET, F.C.S., has been appointed to succeed Mr. C. Watt, as Government Analyst.

THE Senate of the Sydney University have granted an application from Mr. W. Andrews, M.B., Melbourne, for admission, *ad eundem gradum*.

DR. BOHESMANN, a native of Sydney, who has just returned from his studies in Europe, has commenced practice at 32 College-street, Hyde Park, Sydney.

DR. F. G. FAILES has commenced practice at Cassilis, in a pastoral district, 223 miles N. of Sydney.

DR. W. FINLAY, late of Kensington, near Melbourne, has commenced practice at Bathurst.

DR. GEO. GOODE, late of Camden, has settled at Orange.

DR. JOHN KERR, a recent arrival, has been elected the first Resident Medical Officer at the Newcastle Hospital, at a salary of £300 per annum; there were twelve applicants for the position.

DR. J. D. LLEWELLYN has commenced practice at Wollongong.

DR. JAS. LAMROCK, a new arrival, has commenced practice at Kogarah, a suburb 8 miles S. of Sydney.

DR. R. T. PATON, a recent arrival, has commenced practice at 253 Oxford-street, Paddington, a suburb adjoining Sydney.

DR. SPOFFORTH, a recent arrival, has commenced practice at 5 Wentworth-terrace, Argyle-place, Sydney.

DR. C. G. THORP, of Mudgee, met with a serious accident on January 3rd. He was driving a buggy and a pair of horses, when they took fright and bolted, throwing him out with severe force. He remained unconscious for some time, and is suffering from concussion of the brain.

MR. T. B. MELHUISH, Pharmaceutical Chemist, of 134 William-street, Sydney, has just received a fresh supply of Salol, Lanoline, Urethane, and other new chemicals.

NEW ZEALAND.

THE Government have issued stringent quarantine regulations. All vessels from Australian ports will be subject to medical examination on arrival, and will be compelled to carry a qualified Surgeon.

DR. T. E. FRANKLIN, of Sydney, and Dr. George Fox, of Melbourne, have been appointed house physician and house surgeon respectively at the Auckland Hospital, *vice* Dr. J. H. R. Bond, resigned.

WILLIAM BROWN, L.R.C.P. & R.C.S., Edin., died last month at Palmerston, Prov., Otago, at the early age of 38 years, after an illness of only a few days' duration. The deceased gentleman was a native of Dundee, Scotland, and came to New Zealand in 1872. Shortly afterwards he settled in Palmerston, and gradually acquired a very extensive practice. His district being a very large one, only a man of excellent physique could stand the work, as rides of twenty to fifty miles were of common occurrence. He was never deaf to the call of those who wanted his assistance, and no distance, nor slight prospects of remuneration, influenced him in his work.

DR. G. D. PORTER has commenced practice at Carterton, 51 miles N.E. of Wellington.

SOUTH AUSTRALIA.

A MEETING of subscribers to the Intercolonial Medical Congress was held on December 11, and Dr. Verco was unanimously elected President of the Congress, and an Executive committee was appointed. Encouraging letters have been received from medical men throughout Australasia, India, and England, promising support, and probably attendance at the Congress to be held in Adelaide during the University vacations in August and September of next year.

THE Government have approved of the expenditure of £3000 in making alterations and improvements in the Adelaide hospital. The work will be carried on under the supervision of the superintendent of public

buildings, whose report as to the necessary alterations has been approved of by the board. The floors of all the wards will be taken up and relaid with jarrah timber, which from its hardness is not likely to harbour germs like soft wood. The ventilation and sewage will receive special attention.

DR. T. C. BENNETT, a recent arrival, has settled at Moonta, a copper-mining township on Yorke's peninsula, 135 miles N.W. of Adelaide.

DR. L. W. BICKLE, late of Silverton (N.S.W.), has commenced practice at Echunga, in an agricultural and mining district, 21 miles S.E. of Adelaide.

DR. ARTHUR RICHARDSON, formerly of New Zealand, has commenced practice at Teetulpa, the new gold fields township, not far from Adelaide.

TASMANIA.

We have received a copy of the Register of Dentists kept at the General Registrar's Office, Hobart, in pursuance of the Dentists' Act of 1884, which came into force on January 1, 1885; the number of dentists thus registered is twenty-seven.

ON December 8, 1886, in the Tasmanian Parliament, an Act was passed for regulating the sale and use of Poisons; also an Act to provide for the inspection of the carcases of pigs in Hobart and Launceston.

VICTORIA.

AT the fortnightly meeting of the board of management of the Melbourne Hospital, held on December 14, a deputation, consisting of Drs. Robertson, Girdlestone, Webb, Fitzgerald, and Williams, were present, and urged the necessity of immediate steps being taken to cope with the defects of the institution. Dr. Robertson demanded a reduction of the number of beds in the medical wards which are under his care, in view of the commencement of the typhoid fever epidemic. Mr. Fitzgerald adhered to his opinion that the hospital is in a completely insanitary condition, and gave specific instances in which septic disease had been contracted by patients after operations in the hospital. Mr. Girdlestone attributed the whole of the existing evils to the faulty construction of the hospital, and among other suggestions recommended that temporary tents should be erected in the grounds for the reception of surgical cases. Dr. Williams suggested that tents should also be erected to accommodate fever patients. Typhoid fever, he remarked, was likely to be very prevalent this summer, and such cases could not be turned away. Mr. Webb concurred generally in the views of his colleagues. The committee declared that they were quite at one with the medical staff in their desire to remedy the existing state of things, and appointed a sub-committee to confer with four of the medical officers upon the matter.

THE members of the honorary medical staff of the Melbourne Hospital met on December 16, for the purpose of electing a sub-committee to act with the gentlemen appointed by the committee of the institution to consider the condition of the hospital, and to make arrangements for the temporary accommodation of typhoid fever cases. The gentlemen elected were Mr. Fitzgerald, Mr. Girdlestone, Mr. Webb, and Dr. Robertson.

FOUR cottages are being erected at Kew, within the grounds of the lunatic asylum, where imbecile children are to be lodged and instructed.

THE Alfred Hospital, Melbourne, is now receiving paying patients at £4 4s. per week in Class A, and £2 6s. in Class B.

A HOSPITAL is to be erected at Bairnsdale, in Gippsland; the foundation stone was laid on the 15th December.

AT a meeting of the Central Board of Health, held on December 10, a report was received from Mr. W. T. Kendall, M.R.C.V.S., on the subject of typhoid in swine. Although there was sometimes great mortality amongst swine, the cause was anthrax measles, or some ailment of dietetic origin. No case of typhoid amongst swine in this colony had been authenticated. It was highly contagious amongst swine, the symptoms being eruption of the skin, fever, and in the latter stages ulceration of the lining membrane of the intestines. The cause of the disease was the insanitary conditions of the place, and unwholesome and filthy food. He was not aware whether the disease was communicable from the animal to man, but thought there would be great danger in even handling the flesh of pigs so diseased.

TYPHOID fever is very prevalent in the colony, especially in the suburbs.

TYPHOID Fever and Diphtheria are very prevalent just now in the Echuca district.

E. P. NESBITT, a South Australian solicitor, applied to the St. Kilda (Melbourne) Bench, on January 7th, for the issue of a summons against Dr. Edward Simmons, of St. Kilda, charging him with falsely stating under the Lunacy Statute that he (Nesbitt) was dangerous to himself and others, and causing him to be confined in a lunatic asylum. Nesbitt, in conducting the application, was very eccentric. We are glad to state that the Bench refused the application.

THE Victoria Trained Nurses' Association Building in George-street, East Melbourne, was opened on December 17, by Lady Stawell, in the presence of several ladies and gentlemen.

DR. W. COTTERELL, late of New Zealand, has succeeded to the practice of Dr. Jakins at Ballarat.

DR. H. CROSSEN, late of South Melbourne and formerly of Echuca, has returned from his trip to England, and resumed practice at 163 Collins-street East, Melbourne.

DR. W. C. DAISH, late Resident Medical Officer at the Melbourne Hospital, has started practice at 48 Howes-crescent, South Melbourne.

DR. C. P. W. DYRING, a graduate of the Melbourne University, has commenced practice at Coburg, 5 miles N. of Melbourne.

DR. MACANSH has commenced practice at Brighton, a favourite watering place, 7½ miles S. of Melbourne.

DR. CHAS. MULLER has settled at Colac, in an agricultural and pastoral district, 96 miles S.W. of Melbourne.

DR. JOHN REID, late of Port Germein (S. A.), has commenced practice at 11 Spring-street, Melbourne.

DR. T. K. ROBINSON, a recent arrival, has commenced practice at Bairnsdale, in a grazing and farming district, 185 miles E. of Melbourne.

DR. C. W. ROHNER, late of Yarrawonga and Tungamah, has removed to Phillip Island.

DR. C. Y. SHUTER, late Resident Medical Officer of the Creswick Hospital, has succeeded to the practice of Dr. W. Finlay, at Kensington, near Melbourne.

DR. BERNARD STEVENSON has settled at Healesville, 38 miles E. of Melbourne.

WESTERN AUSTRALIA.

THE following gentlemen have been appointed members of the newly formed Central Board of Health, for superintending the execution of "The Public Health Act, 1886":—A. R. Waylen, M.D., Colonial Surgeon, to be Chairman; the Hon. J. A. Wright, Director of Public Works, M.L.C.; Julian F. Harper, Barrister-at-Law; Barrington C. Wood, J.P.; James Manning, J.P.

LIEUTENANT-COLONEL CHARLES D'OVLY FORBES, has been appointed Secretary to the newly formed Central Board of Health in Western Australia. Local Boards of Health have also been appointed for the city of Perth and the town of Fremantle.

MEDICAL APPOINTMENTS.

Anderson, James Fisher, L.R.C.P. & R.C.S. Edin., to be Government Medical Officer and Public Vaccinator at Cootamundra, N.S.W.
 Bennett, Thomas Charles, M.B. & Ch.M. Aberd., to be Public Vaccinator at Moonta, S.A.
 Blair, David, M.D. Glasg., to be Public Vaccinator for the District of Gabriel's, N.Z.
 Cuppidge, John Loftus, M.D. & Ch.B. Dub., to be a Surgeon in the Queensland Defence Force.
 Forbes, Armitage, L.R.C.P. Ed., L.R.C.S. Irel., to be Government Medical Officer and Vaccinator for the District of Tweed River, N.S.W., *vice* Dr. J. A. Pybus, resigned.
 O'Connor, David Watkins, L.R.C.P. & R.C.S. Edin., to be a Surgeon in the Queensland Marine Defence Force.
 Ovenden, William Henry, L.R.C.S.I., L.K.Q.C.P. Irel., to be Honorary Surgeon of the Kaiapoi Rifle Volunteers, N.Z.
 Perceval, Montagu William Cairns, M.R.C.S. Irel., to be Health Officer for Borough of Clunes, Vic.
 Rohmer, Charles William, M.D., to be Health Officer for Shire of Phillip Island, Vic.
 Taylor, David, M.B. & Ch.M. Aberd., to be Health Officer for Shire of Omeo, Vic., *vice* Dr. H. A. Samson, resigned.
 Walpole, George Albert, L.R.C.S. Irel. & L.R.Q.C.P. Irel., to be Health Officer and Public Vaccinator for Shire of Rosedale, Vic.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Franklin, Thomas Evans, L.R.C.P. Edin., 1883; L.A.H. Dub., 1883; L.R.C.S. Edin., 1883.
 Campbell, Loftus, L.R.C.P. Edin., 1883; L.R.C.S. Irel., 1883.
 Lamrock, James, M.B. & M.S. Edin., 1883.
 Gwynne-Hughes, Devereux, L.R.C.S. & R.C.P. Edin., 1886.
 Spofforth, John, L.R.C.P. Edin., 1879; M.R.C.S. Eng., 1876.
 Bonnici, Fernand Henry, L.R.C.P. Lond., 1886; M.R.C.S. Eng., 1886.

For additional registration:

Ross, Chisholm, M.D., Sydney, 1880.
 Sinclair, Eric, M.D. Glasg., 1886.

NEW ZEALAND.

Porter, Guy David, M.R.C.S. Eng.

SOUTH AUSTRALIA.

Bennett, Thomas Charles, M.B. & Ch.M. Aberd., 1886.
 Fry, William W. B., M.B. & Ch.M. Edin., 1881.

TASMANIA.

Singleton, Francis Elliot Corbet, L. & L. Mid. R.C.P. & R.C.S. Edin., 1874.
 Muirhead, Michael Alexander, M.R.C.S. Eng., 1883; L.R.C.P. Lond 1884.

VICTORIA.

Robinson, Thomas Kerslake, L. & L. Mid. R.C.P. & R.C.S. Edin. 1885; L.F.P.S. Glasg., 1885.
 Fox, George, M.R.C.S. Eng., 1880; L. & L. Mid. R.C.P. Edin., 1881.
 Keogh, Arthur George, M.B. & Ch.M. Glasg., 1884.
 Forbes, Henry Farquharson, M.B. & Ch.M. Aberd., 1886.
 Müller, Charles, States Examin., Germany, 1883.
 Perceval, Montagu William Cairns, L. & L. Mid., 1877, M., 1883
 R.C.S. Irel.
 Boyd, William Robert, M.B. Melb., 1886.
 Anderson, Alfred Victor Millard, M.B. Melb., 1886.
 Carney, John Henry, M.B. Melb., 1886.
 Kilpatrick, William, M.B. Melb., 1886.
 Mullen, William Lowell, M.B. Melb., 1886.
 Manson, John Frederick William, M.B. & Ch.B. Melb., 1886.
 Parry, Alfred Alexander, M.B. Melb., 1886.
 Ryan, Thomas Francis, M.B. Melb., 1886.
 Roseblum, Edward Emerson, M.B. Melb., 1886.
 Dyring, Carl Peter Wilhelm, M.B. Melb., 1886.
 Thomson, James Service, M.B. Melb., 1886.
 Rennie, George Campbell, M.B. Melb., 1886.
 Wilkinson, Arthur Mackenzie, M.B. Melb. 1886.
 Locelli, Robert James, M.B. & Ch.B. Melb., 1886.

AN alarming outbreak of smallpox occurred on board the North German Lloyd mail steamer "Preussen," which arrived in Sydney from Bremen, *via* ports, on December 26. The first patient, an Englishman, who came on board at Port Said, died at sea. On January 10th, there were at the Sydney Quarantine Station not less than 76 cases of smallpox, and 24 persons were under observation, with suspicious symptoms. From the beginning there have been isolated 111 persons, of whom, as above stated, 76 have developed smallpox, and 24 were under observation; only 8 have turned out not to be smallpox, and have consequently been discharged to the healthy ground. Three cases terminated fatally. Besides these there were 4 cases of smallpox at the Adelaide Quarantine Station, and 26 cases at the Melbourne Quarantine Station. All the cases mentioned are confined to the crew and the steerage passengers.

WE have received from Messrs. Burroughs, Wellcome and Co., Planet Chambers, Collins-street East, Melbourne, a case containing specimens of their new and useful pharmaceutical preparations, such as Extract of Malt, Hazeline, Beef and Iron Wine, Kepler's Codliver Oil, Valloid of Cascara Sagrada, Zymine, Pepsin, Voice Tabloids of Cocaine, &c., &c., and we are requested to state, that Messrs. Burroughs and Wellcome will be happy to forward such specimen cases to medical men free of charge, on application, as also a good supply of direction-slips for preparing peptonized milk, for distribution among their patients, if desired.

REPORTED MORTALITY FOR THE MONTH OF NOVEMBER, 1886.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Measles.	Number of Deaths from								
						Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	125,000	327	216	117	...	3	2	6	2	24	13	14	4	5
Suburbs	175,000	837	396	253	...	4	4	17	5	41	28	12	5	12
NEW ZEALAND.														
Auckland	33,161	122	27	11	2	1	1	..	1	4	1	1	4	1
Christchurch	15,265	38	8	3	..	..	..	..	..	..	3	1	..	..
Dunedin	23,243	54	20	8	1	2	..	..	..	..	3	1	2	3
Wellington	25,945	80	26	10	1	..	..	..	..	..	3	2	3	3
QUEENSLAND.														
Brisbane	32,571	125	45	27	{	3	..	6	14	5	5	3	3	2
Suburbs	19,112	85	54	26	..	..	..	..	..	..	..	..	..	..
SOUTH AUSTRALIA.....	317,049	870	309	143	11	6	4	37	26	7	24	6	10	
Adelaide	58,000	80	67	25	2	..	2	2	7	7	7	..	3	3
TASMANIA.														
Hobart	29,578	85	29	13	..	2	..	..	1	2	1	2	2	9
Launceston	18,674	63	30	20	1	..	..	..	3	2	3	5	1	..
Hospitals, Asylums, Gaols, &c. .	1,284	...	35	...	..	..	..	..	..	..	..	..	..	..
Country Districts.....	86,243	258	81	..	..	3	..	1	1	..	..	..	..	..
VICTORIA.														
Melbourne	69,774	168	99	357	3	13	5	1	111	61	31	5	40	
Suburbs	275,606	967	566	..	..	..	..	..	..	..	..	..	..	..

METEOROLOGICAL OBSERVATIONS FOR NOVEMBER, 1886.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Inches		Depth.	Days.	
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	99·1	67·8	46·5	29·890	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	150	75·	61·	47·	..	1·410	11	62	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	156	92·	75·9	55·	30·022	9·36	14	65	N.E.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	148	80·4	56·7	37·6	..	767	9	70	..
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	136	77·	56·9	37·	..	2·872	8	69	..
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	92·	59·	40·5	29·857	2·88	12	72	..
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	...	82·4	61·5	38·8	29·935	2·38	8	71	..
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	95·4	61·9	43·8	29·909	2·67	6	..	..	..
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.....	90·1	68·8	53·9	30·025	5·53	14	68	ENR.	..
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	145	69·3	55·9	39·	..	4·266	13	83	..

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

A CASE OF CEREBRAL TUMOUR.

READ BEFORE THE MEDICAL SECTION OF THE ROYAL SOCIETY OF N.S.W.

BY R. SCOT SKIRVING, M.B., HONORARY PHYSICIAN TO THE CHILDREN'S HOSPITAL, AND ASSISTANT PHYSICIAN TO THE PRINCE ALFRED HOSPITAL, SYDNEY.

THE case which I wish to bring before your notice this evening is one of cerebral tumour, and presents some points of interest in the matter of the localisation of encephalic disease, the more so, as, treatment proving of no avail, I had the melancholy satisfaction of verifying the diagnosis by *post-mortem* examination.

The patient, a male, aged thirty-three, after a somewhat chequered career, during which he had used stimulants pretty freely, had been sent out here in the hope that his health, which had given way, might possibly improve. What the exact nature of his symptoms were before leaving home I was unable to gather, nor their duration. I saw him for the first time towards the end of January. Answers to my enquiries concerning his previous history were difficult to obtain, owing to the deafness which was one of his leading symptoms, hence certain points were not ascertained which otherwise would have been. So far as I could gather, he seems to have been shewing symptoms for three months previously, that he complained of slight headache, deafness, and loss of sight. I also elicited a fairly certain history of syphilis. On examination I noticed that neither arms nor legs had the vigour a man of his configuration should have—this was certainly most marked on his right side; in fact, I should call it a condition of paresis. There was slight ptosis of the left eye, and very slight facial paralysis of that side; the left pupil was somewhat dilated. Of the sensory condition of his limbs I cannot speak very definitely, as the difficulty of getting replies rendered the examination too tedious to the patient, and possibly also to the medical man. It was, however blunted. The deep reflexes I found to be normal; the superficial reflexes were distinctly diminished; the organic reflexes were

unchanged. A loss of power of equilibrium was present to a limited extent; it was apparently unaffected by closure of the eyes. There seemed to me, to be only a degree of mental hebetude, which, in part at least, might be accounted for by the interference with two of his special senses. The speech was somewhat thick and slow, but there was no loss of words. The temperature was normal, and remained so throughout. The electrical reactions I had not an opportunity of testing, though doubtless there would have been no change in the limbs save those due to disuse; at some period of his illness "Erbs reaction" would probably have been noted in the face. Aural examination revealed no abnormality in the conducting structures; the "tuning fork test," in so far as it could be used in this case, gave the indication of nerve deafness; the patient ultimately became stone deaf in both ears, the right sharing the fate of the left later on. By the ophthalmoscope I observed a double optic neuritis—the condition of "choked disc" being well marked, especially in the left papilla; vomiting occasionally occurred; there was no nystagmus.

I made no further diagnosis at this time than that of "cerebral tumour," and acting on the specific theory I ordered him iodide of potash. As he was certainly not fit to take care of himself I had him admitted into the Prince Alfred Hospital, where a slight improvement in his condition led me still further into the belief that the nature of the lesion was probably gummatous, although such intermissions are not uncommon in other less amenable forms of cerebral tumours. Perchloride of mercury was now added to the iodide, but he gradually became worse—hearing and sight absolutely failed—saliva dribbled from his mouth, and he lay, helpless in bed, cut off from all communication with his fellow-men. At this time certain other symptoms shewed themselves which assisted me in the localisation of the lesion. An internal strabismus, of not a marked degree, now developed, shewing an implication of the sixth cranial nerve of the left side. That the third nerve, at least some of its fibres, was implicated, was shown by the ptosis, the somewhat dilated state of the pupil, and its absolute immobility to light. I could not satisfy myself that any other branches were involved, because of the impossibility of obtaining answers as to the position of the double images which are seen in the several forms of paralysis of the ocular muscles supplied by the third nerve. It was difficult to work out the implication of the fifth nerve, but, so far as could be learned, there was some diminution of sensibility on the left side of the face. Taking the case as

a whole, the diagnosis I now made was that of "a tumour of, or pressing upon, the pons varolii, with probable implication of the crus cerebri of the left side," the nature of the tumour being probably syphilitic. To sum up shortly the points I relied on in giving this opinion, I may mention the absence of true marked psychical manifestations, the alternate nature of the paralysis (the loss of power in the limbs, though probably obtaining on both sides, being most marked on the right, while the facial palsy occurred on the left side); next, the implication of the abducens, as shewn by the internal strabismus, and the involvement of at least some of the fibres of the third nerve; lastly, there was the existence of complete deafness.

The patient went on from bad to worse, difficulties of speech supervening, and finally, on the 4th of May, curious apoplectiform attacks shewed themselves, without spasmodic motor phenomena, but accompanied by loss of what consciousness remained to him, by snoring, and by congestion of the face. These fits increased in frequency till his death, which occurred on the 22nd of June.

On *post-mortem* examination, there was found a hard, somewhat rounded growth, firmly attached to the dura-mater covering the intracranial aspect of the petrous portion of the left temporal bone, and implicating the auditory nerve on its course to the auditory canal. This tumour had grown inwards between the temporo-sphenoidal lobe on the one hand and the flocculus and a large portion of the left lateral hemisphere of the cerebellum on the other. By its inward growth it had very heavily pressed and flattened out the left half of the pons varolii, and extending further forwards had injured at the same time the left crus cerebri. From this position, which you may note in the specimen before you, it is evident that the diagnosis has been justified. I suppose that the loss of equilibrium may be chiefly accounted for by the pressure on the cerebellum. No doubt also the continued growth of the tumour ended ultimately in interference with the functions of the medulla and the important nerves at that level, hence the symptoms which immediately preceded the termination of his life. As to the nature of the tumour, it has been microscopically examined by Dr. Wilkinson, to whom my thanks are due. He reports that it is a small, round-celled sarcoma. With regard to treatment, it is evident that nothing that we yet know of could have retarded its growth by medicinal means; and even with the vivid light of recent advances in interference with that surgical holy of holies—the brain, I fear that the day of removal of growths situated as this one, is yet in the unknown future.

ANTISEPTIC DRESSINGS.

READ BEFORE THE S. A. BRANCH B.M.A.

By J. A. G. HAMILTON, M.B. DUB., L.R.C.S.
ED., MEDICAL OFFICER OF THE KAPUNDA
HOSPITAL, SOUTH AUSTRALIA.

In making these few remarks upon the antiseptic dressing of wounds, I do not pretend to bring forward anything new, but simply to give my experience of a few dressings, with the object of promoting a discussion upon the various substances in use at the present day for that purpose. Thanks to antiseptic dressings, it is now possible to do away with all of the unpleasant features which were formerly connected with the treatment of wounds. Frequent dressing is not only uncalled for, but is absolutely injurious to healing. Odors need not be produced, and as to profuse suppuration, it may be relegated to the past as a pathological curiosity. Whether a surgeon believes in the germ theory or not, is a matter of small practical importance, but it is certain that the discharges from wounds contain nutritious material for the propagation of bacteria, and the products of decomposition caused by this growth are irritating to a wound, and change the natural order of reparative processes. We are possessed of the means for restraining the development of bacteria. This is to be done by keeping the wounds dry, and allowing a free drainage of all discharges into some absorbent material. Without going quite so far as Mr. Lawson Tait, who asserts that he would use bacteria to pack his pads with if he could procure them in sufficient quantities, still, I believe if the wound be kept dry, and the discharges are not imprisoned, any aseptic absorbent will keep the wound free from danger from without. In order to insure the dressing being aseptic, it has been my habit to use dressings that have been impregnated with corrosive sublimate or some other antiseptic. Instead of dressing a wound every day or two, it is a common thing now for the largest of operation wounds to heal under two or three dressings, and such dressings remain sweet for two or three weeks at a time, so that there is no need for disturbing them in any way. The surgeon has only to look at the temperature chart and leave the wound alone, until a rise in temperature suggests the necessity of changing the dressing. In treating wounds it is necessary to observe the three cardinal points insisted upon by Mr. Sampson Gamgee, in his work on the "Treatment of Wounds," namely :—1. Rest; 2. Drainage; 3. Pressure; for by employing a dry and absorbent material next the wound, with firm and even

pressure, so as to allow the escape of all fluids from the wound, we render the necessity of dressing infrequent, and have everything favorable for healing ; and as long as we have a temperature under 100° F., and the dressing externally dry and comfortable, we may leave the parts untouched without fear or risk to our patient. Every part of the wound should be covered, and for some distance all round, so that the discharges may be all soaked into the dressing and the entrance of bacteria hindered. There was a hope that in absorbent cotton wool a most desirable and generally available dressing had been found, particularly as it was easily impregnated with various antiseptic substances ; but although unequalled as a protective and compressing agent, it has failed as an absorbent material. My observation is that only a limited layer of the cotton immediately adjacent to the wound absorbs, and that this quickly forms a crust which retains the discharges beneath it, and prevents their further escape from the wound. For this reason I would reject it as an immediate dressing, and reserve it only for external protective purposes ; but even here it can be supplanted by cushions of wood-wool, or even fine sawdust ; the latter, of course, can be used at a tithe of the cost. Whichever of these is used may be moistened to advantage with a dilute solution of corrosive sublimate, and made into pads with purified and absorbent gauze. The ordinary cheese-cloth of the shops makes a very good gauze. This should be boiled in a dilute solution of caustic soda or potash, then dried, and finally immersed in the sublimate solution for a short time before it is used, or Hartmann's gauze can be bought ready for use. It is prepared with corrosive sublimate associated with albumen, so as to lessen the irritating effects of the sublimate, as suggested by Lister in one of his recent articles on antiseptic dressings. With these means, pads of any size can be made, the sawdust or wood-wool being prevented from shifting by occasional through and through stitching or quilting with thread.

Hartmann's wood-wool is a soft and pliable material ; it is employed as a substitute for the gauze, and protective of the typical Listerian dressing. It is so flexible that it can be tightly bound on the wound without danger ; it rapidly absorbs and gives off moisture, thus fulfilling the great essentials of a good dressing, *i.e.*, that it should be dry and seldom need changing. I have never found antiseptic dressing in a dry form and of proper strength irritate the wound or adjacent skin ; for this reason I have given up all protectives or air-tight materials, either under or over the dressings, as interfering with the dryness of the wound and the natural exhalations of the

skin. The advantages claimed for wood-wool are briefly : that its absorbent power is so great that wounds remain perfectly dry under its use ; that it absorbs the products of decomposition and probably checks their formation ; that the pads are very soft and elastic, easily adapting themselves to the surfaces of the limbs and trunk ; and finally, it is much less elaborate and costly than the gauze and protective used in the Listerian dressing.

Iodoform is another antiseptic used in combination with wood-wool or any other absorbent which I think is of great value. That it sometimes produces unpleasant effects is not denied, but unless where there is a very large granulating surface, I think it is a safe and efficient antiseptic. I use it powdered finely with oxide of zinc, boracic acid, or starch. In those cases where it appears to be too stimulating, or there is danger of too large a quantity being absorbed, I have been in the habit of using trisnitrate of bismuth dusted over the surface of the wound, and I think it is an equally good and perhaps less stimulating antiseptic. Below I cite a few cases in which these dressings have been used with satisfactory results.

CASE 1.—Male, aged 37. Amputation through right shoulder joint for compound comminuted fracture of humerus. Operation, August 29th, 1884. Wound thoroughly irrigated with sublimate solution, 1 in 2000 ; flaps brought together with silk sutures ; two drainage tubes inserted ; line of sutures covered with iodoform ; a pad of sawdust impregnated with sublimate solution firmly bandaged over the wound. In this case, temperature remained normal throughout. Wound opened for first time on 6th day. Dressings perfectly sweet, and quite dry ; firm union was found to have taken place ; sutures and drainage tubes removed ; dressed as before. This case only required dressing on three occasions. Patient discharged September 30th.

CASE 2.—Female, aged 46. Scirrhus of left breast, with enlargement of lymphatic glands. Operation, December 3rd, 1884. This was an extensive operation of its kind, as the breast was a very large one and all the axillary glands had to be scooped out. Wound was washed with a strong solution of chloride of zinc ; silk sutures were used, and a drainage tube inserted in axillary angle of wound ; line of sutures was dusted with iodoform, and a pad of carbolized tow was bandaged over the wound. No rise of temperature at any time. Dressings opened for first time on 6th day, when primary union was found all along line of sutures, except where drainage tube had prevented union. Sutures and drainage tube removed, and dressed as before. Opened again on 10th day, when healing almost complete.

Patient discharged on December 23rd, the 19th day after operation. The wound only required three dressings.

CASE 3.—Male, aged 59. Ununited fracture of tibia, of 18 months' standing. Operation, April 30th, 1885. Ends of bone freshened and brought together; edges of incision brought together, the wound being well irrigated with carbolic lotion, 1 in 40; dressed with iodoform and a pad of sawdust in sublimate gauze (no wood-wool being procurable); limb put up in box splint. No rise of temperature or pain throughout. Dressings opened for first time on 10th day; wound perfectly dry and healed; dressings hardly stained. (On account of the age and debility of the patient, and the amount of rough handling the bone was subjected to in sawing off its ends, I should rather have expected to have found some suppuration in this case). Removed sutures and drainage tube; put up limb in gum and chalk.

CASE 4.—Male, aged 60. Chronic synovitis of right knee joint, with considerable effusion. Aspiration and all ordinary means having failed to get rid of the fluid, the joint was laid open. Operation, May 30th, 1885. A large drainage tube was pushed through sac and brought out through a counter opening; wound well dusted with iodoform; a large wood-wool pad applied all round joint; limb placed on a back splint. No pain or rise of temperature throughout. First dressing on 10th day; drainage tube removed; no pus; dressed as before. Patient allowed to use limb at end of 3rd week.

CASE 5.—Female, aged 47. Ovarian tumour. Ovariotomy performed March 12th, 1886. A multilocular cyst containing 6 quarts of fluid, with extensive adhesions to bladder wall, was removed; abdominal wall closed with 12 deep and 4 superficial silk sutures; line of incision well dusted with iodoform; small pad of wood-wool in Hartmann's gauze placed over it; more iodoform dusted over this; and a large pad of same material secured with strips of plaster, and a flannel bandage over all. Highest temperature throughout was 99°6 F. First dressing on 10th day, under spray; perfect union was found along whole course of incision; removed sutures, and dressed as before. Second dressing on 20th day. Patient discharged on 27th day after operation.

CASE 6.—Male, aged 33. Fracture of right patella. Accident happened at Silverton, on April 2nd, 1886. Admitted to hospital on April 12th. On examination, knee greatly swollen, a transverse multiple fracture was found, fragments about 1½ in. apart; a small fragment was felt on outside of lower part; put up on a Lawrence's back splint. Cold evaporating lotion constantly applied soon reduced the swelling, but fragments

could not be brought close together, so it was decided to wire them. Operation, April 22nd. A transverse incision was made across joint; the edges of fragment pared; the smaller fragment, about the size of a sixpence, was removed altogether, as it was found impossible to keep it in position. Two holes were drilled in each fragment with Mayer and Meltzer's drill (a very handy little instrument with an eye in point of drill); stout silver wire was used. Joint was thoroughly irrigated with the sublimate solution; a fine drainage tube was pushed through the synovial sac, and brought out at most dependent point, according to Lister's method; edges of wound brought together, and a fine drainage tube placed in inner angle of wound above patella. Wound being well dusted with iodoform, a small pad of Hartmann's wood-wool and gauze was placed over it, a larger pad of same material placed over this, and back and sides of joint being covered with carbolized tow and firmly bandaged; the limb was placed on a back splint, raised at heel to an angle of 35°. Temperature varied from 99° to 99°8, without any pain in the joint until 4th day, when he developed a rather severe attack of pleuro-pneumonia in right lung. Temperature ran up to 102°6. This extended to the other lung, and for some days the case was an anxious one, one lung requiring aspiration. Opened dressings for first time on 7th day; slight discharge of pus from drainage tube in skin flap; good union; removed sutures and inner drainage tube; dressed as before. Second dressing on 14th day; no discharge; complete union; removed other tube. Third dressing on 21st day; wound completely healed. Passive motion was commenced at end of 6th week. Patient has now a useful joint.

The pneumonia in this case was probably caused by prolonged exposure, and use of steam spray at operation, the day being very cold; and considering the state of his health for the first three weeks, the progress of the joint was almost better than one could have expected.

This was my first experience of this operation, and I cannot say that I consider it a justifiable one, at any rate in recent cases.

CASE 7.—Female, aged 56. Ovarian tumour. Ovariotomy, April 20th, 1886. A solid cancerous tumour of the size of a foetal head was removed; adhesions slight; wound treated as in former ovarian case. Highest temperature throughout was 100°6. First dressing on 10th day; primary union. Everything went well until the 12th day, when a faecal smell was noticed around the bed. Upon examination the binder and dressings were found to be saturated with a dirty brown, faecal smelling fluid. The dressings being removed, a

large quantity of same fluid escaped through a small opening about 1 inch to right side of wound (one of the suture holes); the line of suture was entire. On right side a hardness was felt; on pressing this a quantity of faecal matter escaped through the small hole, accompanied by bubbles of air. This continued for 5 days, when the discharge lost its faecal character, and gradually lessened until the 46th day after operation, when the wound was quite healed. The woman is now in good health. In this case the absorbent power of wood-wool was well shown. Although there was an immense quantity of very offensive discharge, large wood-wool pads, changed twice daily, absorbed it all. The question naturally arises, how did this accident occur? The intestine could not have been torn away during the operation, otherwise the case could not have gone on favourably till the 12th day; nor could it have been transfixed by a needle when suturing the abdominal wall, for a large flat sponge was kept over the intestines during the insertion of the sutures, which effectually kept them in; besides, my assistant, Dr. Pentland, held up the abdominal wall and peritoneum between his fingers whilst I introduced the sutures from within outwards. We agree that the accident was caused by a piece of intestine getting looped into one of the ligatures, when tying them after the protecting sponge was removed, and so fastened to the peritoneum, where it became adherent; the bowel sloughing, an abscess cavity formed, its fluid contents escaped through the suture hole. I mention this accident, as my unpleasant experience may be of use to others in operating.

CASE 8.—Female, aged 51. Scirrhous of right breast. Operation, April 5th, 1886. Whole gland removed; wound well irrigated with sublimate solution; silk sutures used; drainage tube inserted; wound dressed with iodoform and a pad of wood-wool. Temperature normal throughout. Opened first on 7th day; primary union; dressed as before; and patient returned home on 10th day after operation, only requiring two dressings.

CASE 9.—Female, aged 75. Strangulated femoral hernia of 5 days' standing. Stercoraceous vomiting and great collapse. Operation, August 26th, 1886. Sac opened and bowel returned; drainage tube inserted; wound dressed with iodoform and wood-wool pad. Owing to extreme restlessness of patient the pad was generally found in the bed every day, but iodoform being freely used, there was no suppuration, and the wound was quite healed on the 17th day. The woman is now convalescent.

I might cite many others, both major and minor operations, in which same treatment was

pursued, but I think these few are sufficient to demonstrate the utility of wood-wool and iodoform.

In all these operations the most strict antiseptic precautions were used. Sponges were first treated with a solution of muriatic acid, then lime water, and subsequently boiled in a solution of carbolic acid, 1 to 40. All dressings, ligatures, drainage tubes, &c., were antiseptically prepared, and only touched by carbolized hands. No material, instrument, or hand was allowed to touch the wound or the vicinity of a wound, unless they had been carbolized or made antiseptic. The steam spray was only used over the wound in the patella case and in dressing the ovarian case. In other cases it was used in the room, but not directly over the wound. In some of the cases the irrigator, containing a sublimate solution, 1 in 2000, was kept almost constantly going over the wound during the operation.

In conclusion, any success I may have had in these operations is mainly due to the able assistance and advice of my partner, Dr. Pentland.

MULTIFORM SKIN ERUPTION.

By J. C. VERCQ, M.D., PHYSICIAN TO THE ADELAIDE HOSPITAL.

L. B., male, age 19, clerk. Came to me on May 10th for cough of one to two weeks' duration. Treated for febrile catarrh. Was next seen in bed on May 14th. On the 11th a rash came out about the face, first below the right ear, then below the left, and then across the forehead. On the 12th some red patches, large and tender, are said to have come on the shins, but they have disappeared again. T. 101. Rash looks like acne. His work is to make extracts from English letters. The mail came in on April 16th with variola.

May 15th—Much backache. More spots about the face, one on right shoulder has a yellow blister, the size of a split pea, without umbilication. None about hands or legs, or trunk below the bust.

May 16.—T. 101·4. Backache very severe especially over the hips, keeping him awake. On the forehead are about forty discrete spots. The spots also come down the cheeks in front of the ears where they are confluent in patches, and then along the line of the jaw to the chin. There is a confluent patch also on the side of the right cheek bone. There are two or three spots on the ear itself, and two or three on the mastoid bone, and scattered spots round the back of the neck. None on the front of the neck or under the chin,

but one just above the clavicle near the origin of the right sterno-mastoid muscle, three in the right posterior triangle, and three below the clavicle. There are seven or eight on the bridge of the nose, two or three scattered about the tip, and several over the lower lip and chin, and one on the mucous membrane of the lower lip, like an ordinary herpetic ulcer. The rash on the left side of the face is not so abundant as on the right. The patch is absent from the left cheek bone, but there are several crowded spots just below and outside the left eye. The spots are bright red raised pimples, rather hard but not shotty, where confluent they look like herpetic patches with papules instead of vesicles. Along the jaw several have suppurated without umbilication. When punctured all the pus can be squeezed completely out. One large one over the right shoulder, which was a yellow blister yesterday, has burst, and now has a very thin scale. One on the left side of the face is like a large acne spot, and though only just showing the sign of a maturity head, yielded when punctured a large drop of pus. There are a few large scattered spots on the shoulder blades.

May 17.—P. 80; T. 101·6. Backache very severe day and night. This morning three erythema nodosum spots appeared on each shin as large as a half crown, raised and red.

May 18.—P. 84; T. 102·6. Bad night. Backache bad but less so. Tongue thin fur, brownish posteriorly. Bowels open. A few spots on the ears and the ridge of the nose. About half a dozen more have suppurated without umbilication, though some have a central black spot. The confluent patches show signs of desquamating without suppuration, and are getting softer and less raised. The erythema spots on the left leg are larger and redder; and a new smaller one has appeared just below the knee on the inner side.

May 19.—P. 92; T. 100·8. Excessive backache all night across the waist. Perspiring freely. No more spots have suppurated. Patches subsiding. The ears, especially the left, seem more irregular on the surface and along the edges. The erythema spots on the left leg have run together, so as to form a large pink erythematous blush. Those on the right leg still indistinct.

May 20.—P. 92; T. 99·6. Spots on the ears are more numerous. Erythema on the legs is fading.

May 21.—P. 80; T. 101·2. Back still aching much causing restless night. Cough less distressing. The suppurating spots have now dry tops and are desquamating over their surfaces. The papular rash is fading in colour and height, and desquamating in small white branny scales. One

erythema spot still above right ankle. Slight diffused redness over left shin.

May 22.—P. 84; T. 100·6. Backache prevented sleep. Rash all fading. Still some cough.

May 24.—P. 100; T. 99·2. Back easier; but pains over left shoulder blade on moving the arm, or deep breathing. Few acne spots maturing on outer parts of the forehead and about the chin.

May 26.—P. 84; T. 99·6. Face nearly clear. Only slight pinkness in site of the papular eruption; few acne spots on forehead, jaws, and chin.

May 29.—P. 92; T. 98·4. Backache gone. Cough still troublesome. Perceptible branny roughness of ears and few common acne spots on face.

May 31.—P. 84; T. 99·6. Pain and tenderness in left loin going down to left groin. Few acne spots.

June 3.—P. 84; T. 98. Only few acne spots.

What gave this case its special interest during the early part of its progress was the bare possibility of its variolous nature. In favour of this were the facts (1) that twenty-five days before the appearance of the eruption the patient had to do with mails from a steamer with an outbreak of variola; (2) the febrile temperature; (3) the persistent and excessive backache; (4) the pustular character of the eruption. The diagnosis of variola was negatived by (1) the incubation stage was too long, that of smallpox being only fourteen days; (2) the rash where papular was not hard and shotty enough; where pustular was not umbilicated, and was monolocular, so that each pustule could be wholly emptied; (3) the course of the rash was not regular; there were some suppurating spots from the first, and these were mingled from beginning to end with papules which never became even moist, and associated with erythema nodosum. He was isolated, however, under the direction of Dr. Whittell, who kindly saw the case with me twice, during its earlier stages, and was kept in quarantine until the differential diagnosis was absolutely established.

Exactly what name to give to the case it is difficult to decide. There was a combination of acne, and papular erythema on the head; an erythema nodosum on the legs; a continued fever, demonstrated to be of at least 18 days duration, and probably of much longer in the onset; and a somewhat severe bronchial catarrh. The designation of catarrhal febrile multiform erythema, seems rather cumbrous. I am inclined to think it was an erythema in the face of a lichenous disposition, and that the acne spots were probably produced by the irritation of the sebaceous follicles by the erythema.

TRACHEOTOMY IN CROUP AND DIPHTHERIA, WITH NOTES OF FIVE CASES.

READ BEFORE THE N.S.W. BRANCH B.M.A.

BY WM. HY. CRAGO, L.R.C.P., LOND.,
M.R.C.S.E.

(Continued from page 67.)

(3.) Late in the evening of Easter Sunday last (April 25th, 1886), I received a message to visit a child in Walker Street, Redfern, a girl, aged 7 years. On arrival, between 9 and 10

p.m., I found her breathing very harshly and troubled with a croupy cough. On examining the fauces I found the tonsils much enlarged and studded with white spots. The temperature was almost normal—child had been bad for two or three days. Ordered wet bandages to throat, and a mixture containing Pot. Chlor. et Brom. cum Vin. Antim. Tart. On visiting her about 1 p.m. the following day, found the breathing rather more "croupy" in character, and the child looked haggard, cough rather troublesome; ordered linseed and mustard poultices in place of wet bandages, and a mixture containing Ol. Eucalypti in Emulsion. Towards evening the breathing became so much worse that the father came to me between 5 and 6 o'clock and begged of me to try and do something to give relief, otherwise he was quite sure she could not go through the night. I at once accompanied him, taking with me a tube or two, and on arrival at the house found the child tossing about the bed struggling to get her breath, and becoming markedly cyanosed. Having obtained the assistance of Dr. Parker, who administered an anæsthetic, I proceeded to open the trachea making only a short incision about 1 inch in length commencing a little below the thyroid cartilage. Two probes bent at right angles served as retractors, but I proceeded more by sense of touch than sight—taking care to keep in the middle line, but paying no attention to the thyroid isthmus. Having laid bare the upper part of trachea I divided the 2nd, 3rd, and 4th rings and passed in a pair of dilating tracheotomy forceps through which I passed a large-sized Fuller's bivalve tube, and almost instantly a large piece of leathery membrane was expelled and carried some distance on to a looking glass. Some blood that had run into the trachea was also expelled.

The relief to the breathing was so immediate and perfect in this case that I determined never to hesitate to operate in any similar case. As soon as the effect of the anæsthetic passed off the child was able to swallow some liquid nourishment, and she passed a comfortable night.

I cleaned the tube twice a day myself for a fortnight, and at each cleaning for the first three or four days a piece of membrane was expelled. The highest temp. after the operation was 102° on the following evening, but with that exception it only twice exceeded 100°, varying between normal in the morning and 99°6 in the evening. On one occasion the urine contained over $\frac{1}{8}$ th of albumen, but at the end of three weeks there was scarcely a trace. The exudation through the tube was copious, but not so viscid as in the first case, and after a week the spasms excited by cleaning the tube caused it to become mixed with blood.

About ten days after the operation saliva and fluids began to come through the tube—this at first caused me a little uneasiness, as I once saw a case in London where the tube had caused an ulceration through the posterior wall of trachea into oesophagus; but further examination dispelled this fear, and I attributed it to some defective action of the muscles of deglutition in not properly closing the epiglottis, as solids were easily swallowed. At the end of fourteen days I substituted a small black vulcanite tube for the metal one, and this appeared to have the effect of diminishing the amount of discharge and of causing a healing tendency in the flesh wound, as after a few days the wound presented the appearance of a round hole just the size of the tube. The power of swallowing liquids also much improved, and the voice returned two or three days before the tube was left out at the end of three weeks. It might safely have been dispensed with two or three days earlier, but it caused no inconvenience and the child preferred to retain it. The wound in the neck rapidly healed and the child rapidly regained strength. Saw her 30th ultimo; quite well.

(4.) As this case presents some features of interest, I will relate it a little more fully than the others. It was that of a boy aged 6 years. I first visited him on May 11th, 1886, when he had been complaining of a sore throat for some two or three days. The tonsils were enlarged, and the inner surface of each covered with a white membrane. Tongue thickly furred, and breath offensive; complained of great difficulty in swallowing; the temperature was near the normal. Ordered wet compresses to throat, Pigment of Liq. Sodii, Chlor. cum Glycer. to be applied locally to tonsils, and a mixture containing Sodii Sulpho-Carb. to be taken every four hours. The breathing on my first visit was not croupy.

At noon on the following day there were a number of "white spots" on the tonsils, and also one or two on the uvula. The breathing was now

slightly croupy in character. Ordered inhalations of Ol. Eucalypti, and Sulphur to be blown into the fauces alternately with the application of the pigment, but the patient struggled so much that the brushing had to be abandoned. At 9 p.m., the same day, the white spots were not quite so distinct, but there was no improvement in the breathing.

May 13th.—Fauces were still much swollen, and there was whitish membrane on insides of tonsils and on back of pharynx. Voice and breathing more "croupy." At about 4 o'clock in the morning had had such a severe paroxysm of dyspnoea that poulticing and an emetic of Vin. Ipecac. were resorted to. Temp. 99°4.

May 14th.—Child had had another bad night, and, in spite of emetics, the breathing was getting more and more laboured, expiration being almost as difficult as inspiration. Seeing the progressive nature of the obstruction, I had pointed out the necessity that might arise for performing tracheotomy as the only hope of saving life, and as at 9 p.m., the obstruction seemed greater than ever, and the retraction of the spaces above the sternum and clavicles being very marked (as well as the epigastrium) during inspiration, the parents dreaded risking another night and decided on having Tracheotomy performed. Accordingly, with the assistance of Dr. Harper-Crewe, I performed the operation between 10 and 11 p.m. the same evening (*i.e.* May 14th, 1886). The child having been brought under the influence of an anaesthetic and the head thrown well back by means of a hard pillow—made by rolling a wine bottle in a towel—placed under the shoulders, I made an incision about $1\frac{1}{2}$ inch in length, commencing just below the thyroid cartilage, the cricoid and upper rings of trachea were speedily and easily exposed. I divided the upper two or three rings of trachea—but not the cricoid—keeping above the isthmus of thyroid gland. The bleeding was not at all alarming. On introducing the tube some viscid mucus was expelled, but some time elapsed before the pulse and respiration were at all satisfactory, and the frequent passage of a feather was necessary to excite spasm. As the incision seemed to be higher than necessary, I inserted two silver wire sutures and brought the edges of the upper part together; after about half-an-hour the child's condition was more satisfactory.

On visiting him the next morning at 9, I found he had passed a good night, and was then sitting up in bed playing with some toys, and breathing quite comfortably through the tube. Shortly before 3 p.m. of same day I was hurriedly summoned, being informed that the child was in convulsions. Fortunately I was at home and

went at once. On arrival I found the patient in a semi-asphyxiated condition—his lips and hands being quite livid—and struggling to get his breath. I instantly removed the inner tube which was blocked with a very tough piece of viscid mucus almost like a piece of India-rubber. This happened just before the trained nurse that had been engaged arrived at the house, or she would have known what to do. I had instructed the attendants to pass a feather occasionally, but, unfortunately, had not shown them how to remove the tube. Directly the obstruction was removed the child regained his colour, and all alarming symptoms disappeared. I should say that a fire was kept up in the room, with a kettle rigged with a long spout carrying steam into the room. The ends and one side of the cot were closed in with a sheet. On visiting him the following morning I found signs of the disease having spread down the trachea, as even with the tube perfectly clear the breathing was again noisy. There was no moisture about the wound, the discharge being of a dry, tough nature. Thinking a jet of steam might soften the discharge, I ordered a Siegel's spray producer, and, waiting its arrival, directed a jet of Atomized Eucalyptus Oil (in sol.) on to the orifice of the tube, and shortly afterwards he expectorated (through the tube) a piece of hard phlegm, the breathing at once becoming free. By evening some swelling had shown itself under the chin. Temp. 99°8.

On the morning of May 17 I found a large blister on each side of the upper part of wound with considerable swelling under the chin, and also some swelling over the upper part of sternum. Removed the two sutures; there was slight redness around wound; temp. below 100°; child seemed well in himself.

For several days there was nothing of importance to note, except that the swelling under the chin gradually became less. Some of the infiltrated epidermis of blister, which had assumed a leathery appearance, came away about the 20th, leaving a granulating surface underneath. There was very great difficulty in cleaning the wound and tube, as the child struggled so violently, and I thought it wise not to attempt to brush his throat for fear of doing more harm than good, although there were white patches visible there for many days. As in the last case, in from a week to eight or nine days, liquids began to come out of the external wound, more by the side of the tube than through it, in this case, on account of there being no opening on the convex side of the tube.

On the 23rd I substituted a small black vulcanite tube for the silver one, and the change was beneficial, but liquid food continued to escape by

the side of the tube and to cause cough ; but he now began to ask for solid food, which he could swallow well. A slough, which had extended through the cutis vera, now separated. The exudation through the tube became much less, and at end of a fortnight from operation he could speak pretty well, and the tube was omitted altogether on the 1st June, the 18th day after the operation, and the wound covered with a double thickness of lint smeared with Eucalyptus Vaseline. The opening speedily closed, but many weeks elapsed before it had completely cicatrized. No trouble in swallowing was experienced after the removal of tube. During the illness the child had emaciated considerably. After getting up the child walked with a very staggering gait, which, after a week, got so bad that he could scarcely get along without assistance.

On June 29 I have noted : "There is still great weakness of legs, and some difficulty in swallowing liquids. Has an internal strabismus due to paresis of right external rectus.

July 6.—By this time the strabismus had become alternating, due to a paresis of each external rectus, but the boy could walk better. I, with some difficulty, applied galvanism, but this he did not like, and rather than have it continued, consented to take a mixture of Parrish's Syrup, which he had resolutely refused to do before.

At the end of a fortnight the strabismus had disappeared, and he was rapidly gaining strength.

At the time of my last visit, Aug. 5, there was no trace of the strabismus, the wound in neck had completely cicatrized, and the child could run about as well as ever he could, and had gained very much in weight.

(5.) This patient was a little girl named Agnes H—, aged five years.

About 9.30 a.m. on June 8, 1886, her father entreated me to accompany him in a cab, saying the child was very ill, and that there were symptoms of croup. I fortunately put a tracheotomy tube and my pocket-case in my pocket, and at once accompanied him. On the way I ascertained that the child had been ailing for two or three days, but had only taken seriously ill during the previous night. She had been visited at 7.30 that morning by another practitioner, who had ordered two emetics of Cupri sulph., neither of which had taken effect. This gentleman, when sent for again, happened to be out, which was the reason of my being called in. I found the child in an asphyxiated condition, frothing at the mouth and the breathing very shallow, but nothing of a croupy character about it. There was very little air entering the lungs, as shown by the great retraction of epigastrium, &c., &c. On examining fauces I saw a large white patch of membrane covering the inner surface of each tonsil.

The child was almost in a moribund state, being perfectly insensible to speech or touch, and no reflex produced on touching eyeball. The pulse at wrist was scarcely perceptible. For a minute or two I held a jug of hot water under her mouth, but as life seemed to be fast passing away, thought further delay would be fatal. So with the father to hold the head straight, I proceeded to open the trachea. As in case 3 I only made an incision about an inch long, paying no attention to the isthmus of thyroid, only taking care to keep well in the middle line. Not having any retractors with me—nor anyone to use them if I had them—I had to trust more to the sense of touch, constantly feeling for the trachea with the index finger of left hand ; just at the last there was very free haemorrhage, which, I fancy, came from the divided isthmus. After waiting a little while for this to cease, I divided two or three rings of the trachea from below upwards, and passed a pair of dressing forceps through the opening, by means of these I managed to introduce a metal tube. For two or three minutes after the introduction of tube there was a pretty free escape of blood, more by the side of the tube than through it. I passed a feather several times through the tube which caused the expectoration of a quantity of blood and mucus, and after a few minutes the expectoration became white, showing that no more blood was running into the trachea. The breathing soon became easy, and in from fifteen to twenty minutes she regained consciousness and was able to swallow a little brandy and water. Her natural colour gradually returned, and in the course of an hour or two she was looking as comfortable as if there was nothing the matter with her. This case gave very little anxiety or trouble afterwards, although the false membrane in the fauces was very extensive ; I had it brushed twice a day with a solution of Permanganate of Potash. By the 13th the false membrane looked very dark, and came away the following day. The wound in neck never showed any signs of inflammation or swelling. The urine was loaded with lithates and contained a trace of albumen. On the 16th I tried a small vulcanite tube, but it required cleaning so often that the metal one was re-introduced—but finally omitted on the 23rd, fifteen days after its introduction. The highest temp. was $100^{\circ}6$, but seldom reached 100° ; pulse usually from 132 to 144 and feeble. A hard lump formed at right angle of lower jaw, which developed into an abscess, which I opened on the 29th ; and, with the exception of the breathing keeping rather loud, especially at night-time, the child made an excellent recovery, and rapidly regained flesh. The wound closed very rapidly after the tube was left out. I last saw

her Aug. 28th, when she had grown quite plump, and had entirely lost the "croupy" breathing.

I must crave your indulgence for a few minutes longer while I make a short review of the cases as a whole.

It will be observed that four out of the five cases had more or less membranous deposit on the fauces, and were undoubtedly—in my opinion—diphtheritic in nature. I may at once state that I look upon "membranous croup" and diphtheria affecting the larynx or trachea as one and the same disease. No. 1 did not present any membrane at any time on the tonsils, but a large piece of membrane was expelled through the tube at the time of the operation.

In case No. 2 I consider the operation was delayed too long, until the disease had spread into the trachea, and the age of the patient—under two years—was against him; still the relief was very great, and I think the parents were thankful for the relief afforded, although the termination was fatal.

Eucalyptus Oil was freely used in all the cases, either dropped on the pillow or on the auze used to cover the tube, and an ointment of 1 part of Ol. Eucalypti to 7 parts of Vaseline spread on lint was kept applied to the wound under the shield of the tracheotomy tube. In all the cases but one (No. 5), a fire was constantly kept in the room, but in this last there was no fire-place in the room, but a Siegel's spray producer was used several times a day.

As regards the length of incision—the longer it is the easier it is to reach the trachea, but in the two most successful cases (Nos. 3 and 5), the incision barely exceeded one inch in length—still I think about $1\frac{1}{4}$ inch would be better. In No. 4 I introduced two stitches, but rather regretted doing so afterwards, as I blamed them for producing the blisters when swelling commenced, although I fancy the spraying with too strong a solution of Eucalyptus Oil had something to do with causing the swelling.

Anæsthetics were used in cases Nos. 2, 3, and 4, and, I think, should be used in all cases where consciousness exists—although Pugin Thornton, and others condemn their use. In Nos. 1 and 5 the patients were so thoroughly asphyxiated that anæsthetics were not required. The tube should be as large as the trachea will comfortably hold, as there is less risk of its becoming blocked. I show the tubes used in all cases. The two objections I have to Fuller's bivalve tube are (1) that during the spasm excited by the removal of the inner tube to clean it the sharp edges of the bivalve portion may do harm to the mucous membrane of trachea, and (2) that the outer portion or collar is immovably fixed to the inner part or tube. Vulcanite tubes seem to irritate the flesh much less.

In the cases above related, I have thrown the responsibility of the operation on the parents—that is, I have been careful to inform them that there was no certainty of saving the life of the patient, but the operation offered the best chance of doing so, and in all probability would afford considerable relief from suffering. From the experience I have gained in these few cases I consider we are wanting in our duty if we do not respectfully urge the advisability of performing the operation in all cases of laryngeal obstruction which do not yield to other treatment, and that the operation should not be delayed until the child becomes too exhausted, or until the obstruction has spread into the trachea and bronchi. Professor G. Buchanan saved three out of eight, in all cases where he operated when the child was in a moribund condition. Owen, in answer to the question, "When is the operation needed?" says: "The answer is simple—'When an insufficient amount of air is entering the lungs.' The signs of this are a sinking in of the supra-clavicular, supra-sternal, and epigastric regions during inspiration, and a harsh or noisy passage of the air through the glottis. Further evidence of serious obstruction is prolonged and noisy expiration. If there be a doubt as to whether the operation may not be still further delayed, it will generally be better to *perform it forthwith*. When more exhausted, the child will be less likely to benefit from the introduction of the tube. Many a case is lost from tracheotomy having been delayed. At any rate the operation will not prejudice the child's chance."

Howse, in the Guy's Hospital reports for 1875, in a paper on tracheotomy, advocates early operation before engorgement of the lungs has taken place. Another argument in favour of the operation, I think, is, that the air entering the lungs without passing over the membrane in the fauces is less likely to set up a "septic pneumonia."

I have brought these cases under your notice chiefly because I think there is still a difference of opinion amongst us as to the advisability of performing tracheotomy in any case of diphtheria, and I think that, while such a difference exists, it is well that all cases, whether successful or otherwise, should be published. Although my average has been unusually good, I do not for one moment claim any credit for it, and shall be quite prepared for a reversal of the numbers in my next five cases, if ever I perform as many more.

It may be said by some that they would have recovered without the operation, but I have no hesitation in saying that, as far as I am capable of forming an opinion, they would not; and two of the cases (Nos. 1 and 5) were virtually dead at the time of operation.

A CASE OF STRANGULATED OBTURATOR HERNIA—OPERATION, FOLLOWED BY DEATH OF PATIENT.

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SYDNEY.

Mrs. G., aged 60 years, was first seen late in the evening of September 19, 1886. She had been ill since Friday, September 17th, complaining of pain in the lower part of the abdomen and right groin, which was increased on exertion. No sickness, and not much prostration; bowels slightly moved on Saturday 18th; no flatus passed since. The pain came on suddenly after some slight exertion.

On examination, she was seen to be lying on her back, knees not drawn up; tongue slightly furred; temp. 98·6 F.; pulse 90, rather small; abdomen was somewhat distended, resonant, and there was slight tenderness at lower part. In right groin, about over the femoral canal, was a swelling the size of a plover's egg; it was placed below and external to the pubic spine, was tense, circumscribed, movable, not connected with the skin, no impulse on coughing; slightly tender on manipulation, and was apparently anchored in the neighbourhood of the saphenous opening, though it could not be distinctly made out to be coming through the opening, and there was no fullness at the saphenous opening independently of the tumour. The tumour itself gave the impression of being a simple cyst. Patient said this swelling had been "*in statu quo*" for three years, and that it appeared somewhat suddenly, she thought, after some slight exertion. She had been troubled by occasional constipation during the three years. There was no hernia discoverable in any of the other usual situations.

As the signs and symptoms were so indefinite, a small dose of morphia was given, and an enema ordered, and the patient left for the night. Next morning, September 20th, symptoms were aggravated. There had been no passage of faeces or flatus; pain and tympanitis somewhat increased; pulse 100, temp. 99. Patient had vomited once, the vomited matter being bile-stained and grumous-looking fluid. It then seemed certain that the case was one of acute intestinal obstruction, and that probably the tumour in the groin was a simple cyst in the neighbourhood of the saphenous opening, and that there was most likely a knuckle of intestine nipped in the femoral ring behind it. Dr. Collingwood, who saw the patient at that time, came to the same conclusion, and it was decided to cut down and explore.

Patient was anaesthetised, and on cutting down

over the saphenous opening, by the side of the tumour, the femoral ring was found to be perfectly free. The tumour itself seemed to be a tense, multilocular cyst, with fluid showing through in places; the walls were fibrous, with here and there some fat. It was easily separated by the fingers from the surrounding structures, except on the deep surface, where a pedicle about the size of the top of little finger passed deeply down among the adductor muscles, and led to the obturator foramen, the bony margin of which could be distinctly felt. As the fluid could not be pressed back into the abdomen through the obturator foramen, and also there seemed to be two or three small cysts situated in the walls of the main cyst, it was concluded that the case was one of an omental obturator hernia which had become cystic, and by dragging upon the intestine had caused the obstruction. It was decided to ligature the pedicle and remove the omentum, leaving the stump in the obturator foramen. On carefully teasing through pedicle with dissecting forceps previous to transfixing it with a ligature, the main cyst burst, and exposed a small knuckle of strangulated gut, black, but still shining, and closely adherent all round the neck of what now turned out to be a hernial sac, thus preventing the return of the contained fluid into the abdominal cavity, and converting the sac into a tense cyst. The adhesions were evidently of old standing, and the strangulation had been caused by more gut and more sac having been forced through the opening by the slight exertion referred to on the morning of the 17th.

Evidently a portion of the hernia had existed unreduced, but not strangulated, for three years, the gut meanwhile having become adherent to the neck of the sac.

The gut was freed, and found to have been very tightly nipped, but peritoneal coat being shiny, and there being no sphacelated patches, it was returned to the abdomen. The neck of the sac was ligatured, and the sac removed, the stump being placed in the aperture. The wound was sutured, a small drainage tube being placed in lower angle, and a dressing of salicylic wool applied. Morphia was given, and the usual treatment was carried out. Three hours after operation patient was free from pain, had passed flatus, and there was no more vomiting. All went well until the morning of 22nd, nearly 48 hours after operation, then no more flatus was passed, abdomen began to be distended, temp. rose to 100, pulse 120, and vomiting commenced, which, however, was never at any time stercoreaceous. The wound had healed by first intention. In spite of all treatment patient steadily grew worse, though temporary relief was obtained by passing a fine

hollow needle into the distended coils of intestine and drawing off a large quantity of flatus. The intestine seemed to be paralysed. The patient gradually sank, and died on September 25th, the fifth day after operation. Unfortunately no *P.M.* was allowed.

The situation of the hernia, and the condition of the sac above described are both unusual.

There was a feeling of doubt as to whether the fatal issue was due to paralysis of the intestine and peritonitis, or to a re-engagement of a knuckle of intestine in the obturator aperture, though the balance of evidence seemed in favour of the former. At all events, the question of further exploration was negatived by the patient's age and general condition.

CARICA PAPAYA.

THE following is an abridgment of the Report presented by the Sub-Committee appointed by the Medical Section of the Royal Society of New South Wales for inquiring into the properties of the "Carica Papaya."

After describing the botanical characters of the plant, the report mentioned that its uses as a galactagogue were fully confirmed in a communication from the Curator of the Botanical Gardens at Hong Kong, who states that the women use it there with great confidence and excellent results as a galactagogue, boiling the green fruit with an addition of two parts of vinegar to one of water.

The therapeutical experiments of the Sub-Committee were made with a liquid extract containing not more than 4 per cent. of alcohol, a tincture of the ordinary Pharmacopeia strength, and a solid extract of a glutinous consistence.

It was found that the mammary secretion could be abundantly stimulated in more or less dry breasts by dram doses internally, or by topical application. That even in the virgin breast it gave rise to a limpid secretion, but that its effect was transitory, being only of a stimulant character, it being required, for the healthy continuance of the secretion that the drug be followed up by an abundance of nourishing food and the usual tonic medicines. Its galactagogue powers were repeatedly tried with good effect on the same individuals.

Some cases of mammary abscess were quoted where the drug was found very useful in keeping up the secretion in one breast, while the other was under treatment.

It was found that where patients were pregnant it acted as an abortant, though, doubtless, through a different physiological process than that produced by Ergot of Rye.

The plant could be grown to perfection in

Queensland and in the warm coast districts of New South Wales, but not in Sydney, as Mr. Moore, the Botanical Curator's experiments have shown.

The experiments tried with a view to test its solvent power on meat were not considered satisfactory, but the opinion was expressed that such power as was generally attributed to the drug in this particular was exerted on the sarcolemma of muscle, the contents of the sarcous particles becoming released and exposed thoroughly to the action of the gastric juice. It was found to have no solvent action on albumen. The paper expressed the opinion that the solvent action on meat of *Papayotin*, the alkaloid exceeded that of pepsine prepared from the pig's stomach.

It was found, also, that the drug possessed considerable power as an escharotic, and several experiments in cases of warty growths were recorded confirmatory of this property.

It appears that in consequence of this escharotic action, there is great danger of haemorrhage from the stomach if the remedy be not administered after a meal. As a topical application to horny growths, it should be used mixed with borax and glycerine.

The paper concluded by the expression of an opinion that it needed only a little activity on the part of the Medical Section of the Royal Society to secure from the New South Wales Government a site suitable for the growth of the innumerable medical plants now known to admit of profitable cultivation in this climate.

CURIOS FOREIGN BODY IN EAR CAUSING DEAFNESS.

By L. W. BICKLE, M.R.C.S., ADELAIDE, S.A.

RECENTLY an elderly woman consulted me for deafness of three weeks standing, "following a cold." Watch could be heard about $2\frac{1}{2}$ inches from each ear. On examining, both meatus were full. The right meatus was full of simple wax, removed by syringe. The left appeared to be the same, but, after syringing, a little wax came away and then appeared a whitish substance—like a cheesy discharge, and most horribly offensive. The patient said she could not remember ever having had a discharge from the ear. On continuing, the white matter ended and more brown appeared, this came out at last and proved to be the tail end of a cockroach; on closely examining the debris, legs and a wing were found. The woman had felt at first, at odd times, a stinging pain, but had not the remotest idea that any living thing had got in, and her face was a picture when she saw the undoubtedly remains of the offender. Hearing is completely restored.

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF QUEENSLAND.

The general meeting for the month of January was held on Tuesday, the 11th, at the School of Arts, Brisbane.

There were present Drs. Bancroft (in the chair), Owens, Hare, Neill, W. S. Byrne, E. H. Byrne, Gibson, Short, Scholes, Campbell, Taylor, O'Doherty, McNeilly, Von Lossberg, and Love.

Drs. Ryan of Gympie, and Thorpe of H.M.S. "Palermo," were introduced as visitors.

Dr. Scholes exhibited a case of chyluria—a lad of 16 years of age—with a microscopic demonstration of the living filariae in the blood, and a sample of the urine.

Dr. Owens shewed two foreign bodies (granite and steel), which he had removed from the anterior chamber, and read notes of the cases. Also, a patient with a foreign body in the anterior chamber encapsulated on the surface of the iris, which had lain there for ten years, and was only then beginning to be troublesome.

A ballot for membership was taken with the result that the following gentlemen were elected members of the Society.

H. Clatworthy, M.R.C.S., L.S.A., of Beenleigh ; W. Grant Furley, M.R.C.P.E., M.R.C.S.E., Brisbane ; J. Clement Ellison, M.B., M.R.C.S., Brisbane ; W. Simpson Webb, M.R.C.S.E., L.R.C.P.E., Brisbane ; Albert Dunlop, M.R.C.S.E., Ipswich Hospital ; Francis M Geoghegan, M.D., M.S., Southport.

The code of rules which had been drafted for the Society was then read, and with a few emendations, adopted.

A ballot was then taken for a Vice-President, two Auditors, and three Trustees, which were required by the code of the rules, with the following result :—Vice-President, Dr. J. H. Little ; Auditors, Drs. Owens and E. O'Doherty ; Trustees, Drs. Rendle, Scholes, and Campbell.

The President read Dr. Rendle's letter of resignation of the Secretaryship, when it was decided to accept it with regret, and to forward to him the hearty thanks of the Society for his able and unwearied efforts in establishing the Society on a firm basis. Dr. Love was then unanimously elected Secretary.

Owing to the lateness of the hour, Dr. Hare kindly consented to postpone his paper on Typhoid Fever till the following meeting, Feb. 8th.

In our review on "Pritchard's Work on the Diseases of the Ear," in last month's issue of the *A. M. Gazette*, we took exception to the statement that in abscess of the brain "treatment is of no avail," and jocularly hoped it might prove a "nut to be cracked." It now will surprise and interest our readers to learn that on perusing the *B. M. J.* of December 11, 1886, which reached us on the same day as the *A. M. G.* was published, we found a case of abscess of the brain, due to otitis media, which had been successfully operated on by trephining and drainage—"the first case in which a cerebral abscess, due to tympanic suppuration, has been correctly diagnosed, localised, and evacuated by operation with complete success." Critically speaking it is an anachronism to call our remarks a prophecy as they were written after the operation in question, but when it is remembered that we are at the antipodes it may be granted that our aspirations at least, in these southern climes, are, at any rate, *en rapport* with the advances of modern surgery.

REVIEW.

Gout, and its relations to Diseases of the Liver and Kidneys. By ROBSON ROOSE, M.D., F.R.C.P. ED. London : H. K. Lewis, 1887.

THERE have been much independent thought, study, and research bestowed on this volume. In the chapter on the theories as to the nature of gout, the author gives a short account of the various theories now in vogue with regard to the pathology of gout, at once interesting, and paving the way for the introduction of his own particular views. The author's theory with regard to gout recognises the cause of the disorder in the presence of abnormal quantities of sodium urate in the blood. Many of the symptoms are indicative of nerve disturbances ; but these latter are due to the poisonous action on the nerve centres of the materials formed in the body, and resulting from imperfect metabolism. This imperfect transformation is for the most part due to functional disorder of the liver. If this be so, it seems strange that gout should be so uncommon in hot climates where functional disorders of the liver are so frequent. It appears to us, that other factors than hepatic disorder are answerable for most forms of gout, though it is certain that most gouty subjects suffer from hepatic as well as cardiac and renal affections.

Visceral and cutaneous affections in gouty subjects are well described, while the chapter on the treatment of gout and its various disorders is an able résumé of what is best and most approved.

The work is decidedly worthy of careful perusal, and we cordially commend it to those who desire to have the existing state of knowledge of gout and its protean manifestations in a short, clear, and readable form.

The author's peculiar views are entitled to our respect and consideration.

LETTER TO THE EDITOR.

FURTHER COMMUNICATION ON DRUMINE.

(*To the Editor of the A.M. Gazette.*)

SIR,—I have used this alkaloid for catarrh of the stomach and duodenum (indicated by dark motions and gripping pains) common in hot weather and after draughts of cold water. I have found it very beneficial; but this was natural from its good effect in catarrh of the nose. We shall probably find it valuable in catarrh of other organs, more especially gonorrhœa. The effects of corrosive sublimate injections will thus be rendered much more safe. I merely hint this last, but I can safely point to its not producing constitutional effects like cocaine even when spread over extensively denuded surfaces.

JOHN REID, M.A., M.D.

11 Spring Street, Melbourne, Jan., 1887.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, FEBRUARY 15, 1887.

EDITORIALS.

ANTICS OF CORONERS IN NEW SOUTH WALES.

FROM the frequent instances which are brought under our notice of the ignorance, unfair bias and absolute unfitness for their position of many of the coroners in New South Wales, it is evident that searching enquiry is much needed into the whole subject. Since our last issue, we have received information from three different districts of cases in which the conduct of the coroners officiating in them decidedly demands criticism.

The first we will notice is one which occurred at Bathurst:—A Mrs. Lowe having died suddenly, Dr. Machattie, practising in that place, was sent for by the police to view the body, and, as a consequence, should have been called at the inquest. Instead of this being done, the coroner, Mr. B. Lee, who is also police magistrate, refused to accept his evidence, but called Dr. W. P. Lee, who happened to be staying with him on a visit at the time. The fact that this gentleman is the brother of the coroner makes his conduct in the case the more flagrant and less excusable. We are of opinion that he acted illegally, for, by the Medical Witnesses' Act, a coroner is directed in cases in which no medical man has been in recent attendance on the deceased, to call as a witness some medical practitioner who resides and is in actual practice near to the place where the death occurred; and this could not be said to have been done when he called in his own brother who chanced to be visiting him at the time, and who resides, when at home, a hundred and thirty miles from Bathurst.

The second case occurred at Gunnedah, and in this also the coroner seems to have acted in an

extraordinary manner. An inquest was held by Mr. P. Brougham and a jury of five on the body of Alfred Bennett, a *post-mortem* was made, and evidence given by Dr. Dowe that the deceased died from natural causes, the jury finding a verdict accordingly. After the verdict was returned and the enquiry closed, upon the irresponsible gossip of bystanders, one of whom happened to be a medical practitioner, the coroner allowed (we can hardly say directed) a second examination to be made, and the stomach to be removed for the purpose of analysis. If the second practitioner, whose name we are informed was Middleton, had reasonable grounds for his assertion that he believed the deceased had died from poison, it was his duty to have brought it under the notice of the police at such a time that he might have been called to give evidence at the original enquiry, and not have waited until a verdict had been given before making assertions for which, we are of opinion, the circumstances of the case gave no justification.

The third case is so extraordinary that it but requires public attention to be called to it to arouse the strongest protest against the continuance of such a gross abuse. In this, it seems that a man named Charles Whittington, who lived at Springfield, near Crookwell, fell from the roof of a shed, receiving injuries, for the treatment of which he applied to a chemist named Prosser, who, without a medical or surgical qualification, practises at Crookwell. After treatment for a week by this person the man died of tetanus, a *post-mortem* examination made by the Government Medical Officer of the district showing that, in addition to a compound dislocation of the middle finger of the left hand, which Mr. Prosser did see, the deceased had fractures of the seventh and eighth ribs on the right, and of the third, fourth and sixth on the left side, and that both layers of the pleura and the lung were perforated by a fragment of one of the broken ribs. These latter injuries remained undetected and, as a consequence, untreated by the chemist, the result of the whole being traumatic tetanus and the death of the patient. The case as related is, we think, enough to arouse loud-voiced demands for enquiry, but what will be thought of it when we inform our readers that the coroner for the district is this same Mr. Prosser, the unregistered medical practitioner who had so sadly overlooked the very serious injuries of the chest which we have enumerated. The coroner, notwithstanding his connection with the case, held an inquest on the body, at which inquiry the sapient verdict was returned "that Charles Whittington died of lock-jaw, the result of injuries accidentally received," nothing, however, being said as to the responsi-

bility of the coroner in his capacity of medical attendant of the deceased for this sad result in having overlooked the serious injuries to the chest walls.

We believe the colony is indebted for the appointment of this coroner to Mr. Garvan, the late Minister for Justice who, in this instance at all events, has proved himself a fitting component part of the Jennings Ministry.

The whole of these cases will, on the meeting of Parliament, be brought before it, and fitting action demanded; in the latter, we know especial interest is being taken by the Hon. C. K. Mackellar, who is not likely to allow so gross an abuse to remain unremedied.

THE FREQUENT CHANGES IN THE RESIDENT MEDICAL STAFF OF THE MELBOURNE HOSPITAL.

A LETTER from Mr. James, one of the honorary surgeons of the institution, was read at a meeting of the committee of the Melbourne hospital on January 11, complaining of the frequent changes in the resident medical staff of the institution. We think that when young practitioners, having just obtained their diplomas, are appointed to these positions, it may fairly be demanded that they shall stop for a definite period, and not leave when it suits their convenience at any time before this period has elapsed. In Melbourne, where the number of students taking their medical degrees each year is sufficiently great to give a constant supply, we think the European method of appointing resident medical officers for a certain period, and requiring them not only to retain their offices for that time, but to retire at the end of it to make room for other men who desire the same opportunity for acquiring experience, is not only politic but just, and should be made an inflexible rule. The generous suggestion of a Mr. Davey, one of the committee, that these young practitioners should do the work not only for nothing, but be required to pay a premium, we cannot endorse; but would suggest that if he feels that the hospital cannot afford to pay the paltry fifty pounds per annum it at present gives them, he should himself try to make it up to the institution, instead of suggesting that the pecuniary sacrifice should come from other men's pockets, probably much less well-lined. However, this vicarious generosity at the expense of the profession is so common to many lay minds that we cannot say we are much astonished by the liberal committeeman's disinterested proposal.

CLUB PRACTICE IN AUSTRALIA.

THE subject of Club Practice is of the greatest interest both to our medical brethren and the public, since it demoralizes the former and tends to pauperize the latter. The original object of friendly societies was to procure medical aid and comforts for those not in a position to pay for them, yet possessing sufficient independence to decline to secure medical assistance as a pauper. One of the conditions being that a member must not be in receipt of more than two or three pounds a week. In England the better classes are allowed to become honorary members only, paying their subscriptions, but receiving no benefits. In Australia the contrary appears the rule, and this ought to make Australians blush. It can scarcely be credited that men in the highest positions in professions, trades, and politics take advantage for themselves and families of clubs intended for the poorer working classes alone. In Victoria we knew cases of Ministers of the Crown, whose State salaries amounted to thousands of pounds per annum, demanding and receiving medical attendance for the princely sum of twenty shillings a year for themselves and their belongings. In this colony, wealthy tradesmen, some of them having retired on a fortune, with the greatest effrontery send for the doctor of the club they joined in their days of early struggle. It never strikes them that they are doing him a great injustice—indeed, we think, defrauding him of his proper fees—shame or conscience seems to have no place in their composition. But what can we think of members of our profession who prostitute their skill, and tamely submit to the demands of such individuals? It is within our knowledge that in the capital of a certain colony a young aspirant to medical fame made a canvass of the members of a society, for which an older practitioner had received thirty shillings per annum for several years, and offered his services for fifteen shillings. In Sydney the clubs are a crying evil to the profession, and their acceptance under present circumstances is often as degrading as unprofitable. We read recently of a benefit society, the committee of which did not contain one poor man, obtaining a medical man for one pound a year for each member. It is difficult to know where the families begin or end, as the grandparents and brothers, to say nothing of "their sisters, their cousins, and their aunts," often coolly demand to be included in the bargain. A grand return this for years of past study and present anxiety, not to mention the hundreds of pounds invested in education.

FEDERAL QUARANTINE.

THE late outbreak of small pox on board the "Preussen," which introduced the disease into three colonies simultaneously, has done what all else had failed to do—induced the colonies to take into serious consideration the necessity for immediately giving practical effect to the recommendations in regard to Federal Quarantine of the Australasian Sanitary Conference which sat in Sydney in September 1884.

New South Wales—whose then chief medical officer (The Hon. C. K. Mackellar) was president of the Conference and the originator of the proposal that Australia should take united action in all quarantine matters—has always been ready to do her share, but has been thwarted by the inertia of the other colonies. Now, however, all are willing to join in what, it is evident, will be a common benefit. The authorities in Victoria are especially enthusiastic, and, judging by the newspaper paragraphs which have appeared on the subject, have almost persuaded themselves that they are the pioneers in the matter instead of being sluggish followers, after an interval of two years, of a suggestion emanating from New South Wales.

We are too convinced of the necessity for a Federal Quarantine System, and too pleased to get it on any terms, to cavil at the way in which it is brought about, but would certainly have preferred it to have been the result of reason instead of the effect of panic. The first step that has been made has been the decision of the Victorian Health Board that the period of twenty-one days is the proper one for the detention of persons after their last exposure to the contagion of small pox. By this decision they admit that the New South Wales Health Board have been right in insisting on this period, and that they themselves have been in error in obstinately differing from the older colony when refusing to detain confinees for longer than 14 days. One anomaly has thus been removed, and a greater probability of general safety from variola insured.

MESSRS. BURROUGHS, WELLCOME & Co., of London, have sent us a sample of "Menthol Plaster," a new form of plaster which they are now introducing to the medical profession. It is made from pure medicinal gums, and is said to contain all the benefits peculiar to the ordinary porous plaster. The particular advantage, however, that they claim for this plaster is the addition of menthol, which they believe to be more efficacious in this new form, as it does not evaporate so quickly. Messrs. B. W. & Co. will feel much obliged by members of the profession giving the same a practical trial at the first opportunity.

THE SYDNEY HOSPITAL.

FOR the information of our readers we republish the following minute of the late Colonial Secretary on his leaving office relating to the above institution :—

"I bring under the notice of my successor in the office of Colonial Secretary the correspondence which exists here in reference to the new buildings of Sydney Hospital and the funds that will be required if the Cabinet decide to complete the present unfinished structure. This subject should be dealt with by the Cabinet before the meeting of Parliament, or at least before the Estimates of expenditure for 1887 are submitted.

"I have been in communication with the Directors of the Hospital and the President of the Board with a view to the removal of the whole of the patients in the wooden structure which 10 years ago was put up as a temporary hospital only, and which has since been universally condemned owing to the liability at any moment of its destruction by fire ; and I have given instructions to the medical adviser, Dr. MacLaurin, to remove from that wooden structure the whole of the pauper patients to safer buildings ; and I learn from him that he has succeeded in removing the whole of the patients to whose support the Government contributes. But there remains still a large number of patients of the ordinary character still exposed to the danger of wholesale destruction in the event of a fire occurring ; and while I have no legal authority, as Colonial Secretary, to compel the removal of these patients (however great may be the danger to their lives, &c., and great it undoubtedly is), I am yet firmly of opinion that, in the interest of humanity, such patients should be removed forthwith.

"But although I have no legal authority to compel the removal, I think the Government should use any means they have to effect the removal of the whole of these patients from a place of danger, and the destruction or removal of the wooden buildings.

"I have offered to give the Directors of the Sydney Hospital every possible assistance in providing other accommodation for the inmates of their establishment ; but, judging from the correspondence which has taken place, the directors are determined to force this or any other Government into the position of deciding to erect the costly buildings now partially constructed before they will make suitable provision of a temporary character for the patients.

"I have offered the Sydney Hospital the use of the old immigration barracks, and to provide labour for the purpose of placing the buildings in good order for temporary use.

"My proposals have not been approved of by the directors, and it will be for my successor in office—whether that successor be the President of the Hospital or not—to carry out to the letter the programme which, in the interests of humanity, I have laid down ; and to go still further—to refuse to pay one penny of any further subsidy towards the maintenance of the hospital until the patients in the wooden building are removed, and until the building itself is taken down.

"(Signed) GEORGE R. DIBBS.
"January 12, 1887."

THE MONTH.

NEW SOUTH WALES.

AMONG the candidates at the present general election for parliamentary honours we notice the names of Drs. Belgrave, W. R. Cortis, Pratt, Renwick, Ross, and W. C. Wilkinson. Dr. W. C. Wilkinson was returned at the top of the poll for the Glebe, on February 5, and on the same day Drs. Renwick and Belgrave were rejected, the former for Redfern, where he polled 500 votes less than the lowest successful candidate, whilst Dr. Belgrave polled not less than 2000 votes below the last of the successful candidates. Dr. Cortis and Dr. Ross have also been elected, the former for Bathurst and the latter for Molong.

IN the Legislative Council, on January 20, Dr. Creed moved the appointment of Sir Alfred Stephen, Mr. Dodds, Mr. Jacob, Mr. King, Dr. Mackellar, Mr. Norton, Mr. Stewart, Mr. Watt, Mr. Suttor, and himself as a select committee to inquire into the state and operation of the laws now existing for the regulation of the practice of medicine and surgery in New South Wales, with power to send for persons and papers, and with leave to sit during any adjournment of the Council. The motion was agreed to.

AT the same sitting Sir Alfred Stephen gave notice of his intention to ask the representative of the Government in the Upper House whether the question of completing the hospital known as the Sydney Infirmary, on the site of the unfinished structure in Macquarie Street, is under the consideration of the Government, and whether the ineligibility of that site, or the greater eligibility of other sites in the vicinity has been taken into consideration by the Government. The same hon. gentleman also gave notice that he would move for the appointment of a select committee to inquire into and report upon the question of the eligibility or otherwise of the present site of the Sydney Hospital. These motions, of course, lapsed through the dissolution of Parliament, but will be reinstated on the business paper of the Upper House, on the reassembling of the new Parliament.

THE number of patients admitted into the Sydney Hospital from January 1 to December 31, 1886, has been 2808. Of these 1771 were surgical, and 1037 medical cases. 2060 were males, and 748 were females. The largest number of admissions was in the month of November, 268; the smallest in the month of July, 200. The number of accident cases admitted was 1091. The number of accidents and urgent cases attended to by the resident medical staff, but not admitted, has been 3388. The number of patients treated at the out-door ophthalmic department for the year ended December 31, 1886, was 433. At the ear, nose and throat department, 152. The number of deaths during the year was 322, viz., 232 males, and 90 females. Of these 112 died within 48 hours of admission, and many others were admitted in a hopelessly diseased or maimed condition for whom the best efforts of the institution were employed to alleviate their sufferings. The number of patients remaining in the house on December 31, 1886, was 173. The number of cases treated by the district surgeons in connection with the dispensary, was 6201. Of these 464 were visited at their own homes.

We learn from the annual report of the Prince Alfred Hospital, Sydney, that there were remaining in the Hospital on December 31, 1885, 135 patients, that 1780 had been admitted during the year, and 1,756 had been discharged or had died, leaving in the Hospital on December 31, 1886, 159 patients. The number of attendances of

out-patients, including casualty cases, had been 19,793. The death-rate, which was 12 per cent. in the previous year, had fallen to 9·97. The increase in the department for out-patients over 1885 was between 3,000 and 4,000. The total number of typhoid fever cases had been 197. This was somewhat less than the year before. The death-rate amongst these cases had been 9 per cent. only, which was considered very satisfactory. No patient had contracted the disease in the wards, and neither officers nor nurses attending on the typhoid cases had been attacked. The collections for the year amounted to £3,909 9s. 1d. Of this sum £3,603 4s. 11d. had been received from in-patients, and £218 6s. 7½d. from out-patients. The total amount was larger by £412 4s. 8d. than that of the year 1885.

AFTER the annual meeting of the subscribers of the Prince Alfred Hospital, Sydney, on January 27, the Governor, Lord Carrington, formally opened a new operation wing, in which provision has been made for 56 beds. There is a clinical theatre; operation theatre, surgeons' room, students' room, instrument room, and special wards for serious operation cases. The whole of these rooms are fitted with the most modern appliances, and appear to be thoroughly complete for the purposes for which they have been designed. The cost of the new wing is £20,000.

AT a meeting of the Board of Management of the Society for the Relief of Destitute Children, Randwick, held in Sydney on February 2, Dr. A. McCormick was appointed visiting medical officer; Dr. Thomas Evans, hon. consulting surgeon; Dr. G. Hurst, hon. consulting physician, and Mr. E. K. Satchell, hon. dentist.

THE N. S. W. Register of Medical Practitioners for 1887 has come to hand. On looking over it we find that the name of 'Sidney Edward Herbert' has been removed, and that the name of 'Joseph Gabbett Bourchier, M.D., Eclectic Med. Coll., Cincinnati, Ohio, U. S. A., 1880, who had been omitted from the Register since 1882, has been restored.

THE annual meeting of subscribers to the Parramatta District Hospital was held on January 31. The report showed that 268 patients had been treated in the hospital during the past year, including 46 typhoid cases. The death-rate was unusually high, averaging 12 per cent. on the admissions. The sum of £360 was received from paying patients, including £304 received from the Prospect reservoir. The total expenditure for the past year was £1276. Drs. Rowling and Phillips were again requested to act as honorary medical officers to the institution.

THE number of patients admitted into the Bathurst Hospital during the past year was 270 men and 83 women, the daily average being 25, and the total number treated 374, while 34 died. During no previous year was the number of patients so large.

THE temporary Cottage Hospital at Moruya has been closed, consequent upon the inadequacy of the subscriptions to defray expenses.

AT the quarterly meeting of the Newcastle Sanitary Association, held on January 30, Dr. John Harris read a paper on the pollution of soil in connection with cesspits.

DR. R. J. PIERCE, Senior Consulting Surgeon to the Maitland Hospital, is arranging to secure the services of a staff of trained nurses to do duty in private houses in times of sickness. He has been in communication with several ladies in the district, who have promised to give the movement their countenance and support.

DR. HERBERT BLAXLAND, Medical Superintendent of the Hospital for the Insane at Callan Park, has been

appointed Acting Inspector-General of the Insane during the absence from the Colony, on leave, of Dr. Frederic Norton Manning.

DR. SINCLAIR FINLAY, a new arrival, has settled at Stroud, the principal town at Port Stephens, 124 miles N. of Sydney.

DR. A. H. FJELDSTAD, a native of Norway, has commenced practice at 39 York street, Wynyard square, Sydney.

DR. V. E. LUDLOW, a recent arrival, has commenced practice at Blane-street, Newcastle.

We regret to have to announce the death of Charles Henry Maher, M.R.C.S.E. Eng., 1884, L., 1883, L. Mid., 1884, K.Q.C.P., Ire., late Resident Surgeon at St. Vincent's Hospital, Sydney, who died last month at his parents' residence, Burwood, near Sydney, from typhoid fever, at the early age of 22 years.

DR. W. MOIR has commenced practice at Bombala, the centre of a mining district, 312 miles S. W. of Sydney.

DR. J. MORTON, of Eden, has succeeded to the practice of Dr. J. M. Brennan, at Milton, the centre of a dairy-farming, and agricultural district, 155 miles S. of Sydney.

DRS. KENNEDY AND LYONS have been elected medical officers to the Albury hospital for the ensuing year.

NEW ZEALAND.

DR. CHARLES JAMES RUSSELL, of Christchurch, was arrested, on January 11, on a charge of procuring abortion. On being taken into custody he swallowed a quantity of aconite. He was at once removed to the hospital for treatment, and though considered out of danger, yet he was too ill to appear in answer to the charge at the Christchurch police court on the following day. A woman named Mary Bowern, who is in custody in connection with the same case, made a statement implicating Dr. Russell, hence his arrest. A further charge has been preferred against him, and a second woman has been arrested, charged with aiding and abetting him. Dr. Russell was committed for trial on two charges of procuring abortion on January 15.

DR. JOHN EWAN has commenced practice at Lyttelton, the seaport of Christchurch.

DR. S. H. HARRIS, a recent arrival from the old country, has settled at Marton, in an agricultural district, 121 miles N. of Wellington.

QUEENSLAND.

DR. E. M. OWENS, Hon. Ophthalmic Surgeon to the Children's Hospital, Brisbane, has been appointed Hon. Consulting Ophthalmic Surgeon to the Toowoomba Hospital.

HER MAJESTY has approved of the appointment of DR. A. F. Kortum as German Vice-Consul at Cooktown.

SOUTH AUSTRALIA.

DR. E. C. STIRLING, M.P., president, and Mr. J. B. Whiting, secretary of the S. A. State Children's Council, have left for Ballarat, Melbourne, and Sydney, for the purpose of inspecting the various industrial and reformatory schools in those colonies.

VICTORIA.

AT a meeting of the Central Board of Health, held on January 14, Mr. Blackett urged that the Governments of the different colonies should be asked to establish a system of federal quarantine. It seemed to him absurd that a vessel which had infectious disease on board should be allowed to go from port to port in the colonies, increasing the likelihood of spreading the disease. The President, in illustration of what Mr. Blackett had said, pointed out that it was the opinion of the health officers at the Quarantine Station that the patients who came by the Preussen became infected after the first patient left Albany. It was much to be regretted that the first patient had not been left at Albany. After some further discussion the President was asked to address the Government in favour of the object in view.

AT a meeting of the Central Board of Health, held on February 4, the President brought up the complaints made by passengers by the German s.s. *Preussen*, regarding the sanitary arrangements and victualling of that vessel, the South Australian Central Board of Health having asked this Board to take action in the matter. It was decided to intimate to the South Australian Board that this Board was willing to ask the Government to send copies of the correspondence to the home authorities, with the view of having it brought under the notice of the German Government.

AT a meeting of the Committee of the Melbourne Hospital, held on January 25, it was resolved that, in future, members of the medical staff should not make their arrangements for taking a holiday on a certain date until the committee had granted leave of absence on such date. At the same meeting Mr. J. S. Butters intimated that he intended to submit a motion to the committee dealing with the system of granting leave of absence, and governing the period for which medical men should be connected with the hospital before they should be allowed to advertise themselves as being "late of the hospital."

THE annual meeting of the Governors of the Melbourne Hospital was held on January 27. The report of the committee stated that the income during the year for the purpose of maintenance, inclusive of £14,000 from the Parliamentary vote and £2,800 from the committee of the Hospital Sunday Fund, amounted to £23,362. The expenditure had been £24,861, and the debit balance had been augmented to £7,708. The amount to the credit of the endowment fund was £25,182. The benefits of the hospital had been extended to 19,398 cases, of which number 15,687 had been treated as out-patients, and 3,791 had been received into the institution. Of these 2,811 had been cured or relieved, 145 had been discharged as incurable or for other reasons, 577 had died, and 238 remained. Of the cases that terminated fatally, 182 died within 72 hours from the time of their admission.

THE sub-committee appointed by the Melbourne Hospital committee to consider the question of enlarging the accommodation of the institution, which at present is much overcrowded, have brought up their report, which is based upon the recommendations of the medical staff of the hospital, and advocates the establishment of five tents or temporary wards in the grounds of the hospital, between the building and Lonsdale street. It is estimated that the cost of erecting and maintaining the proposed extra wards would be about £3,000, which sum the committee recommended should be obtained from the Government. The report did not find much favour with the committee,

who criticised it adversely for several reasons. It was urged that the scheme was crude, impracticable, and too costly for a temporary expedient. The further consideration of the report was postponed for a month.

AT a recent meeting of the Committee of the Women's Hospital, Melbourne, Dr. Balla-Headley, one of the honorary surgeons of the hospital, applied for twelve months' leave of absence to enable him to pay a visit to Europe. At the same time Dr. Headley named a *locum tenens* competent to discharge his duties during his absence. The committee refused the application, on the ground that it is contrary to the regulations of the institution to grant leave of absence. As such applications by honorary officers of similar institutions are usually granted as a matter of course, it is considered that much inconvenience is likely to be caused to the profession should the precedent set by the Women's Hospital Committee be generally followed. It is probable, therefore, that steps will be taken by the profession to assert their rights in the matter.

THE committee of the Melbourne Women's Hospital have decided to accept plans for the erection of the Genevieve Ward wing of the institution. The additions will be somewhat in the form of detached buildings joined by corridors. The cost of the proposed work is estimated at £8,000. The committee of the Hospital have also determined to invite applications for the position of superintendent and secretary. The duty of this officer will be to attend to all business matters connected with the institution, and to promote its interests among the public. The staff is further to be added to by the appointment of an assistant medical officer and a dispenser.

THE annual report of the Geelong Infirmary and Benevolent Asylum shows that during the past year 2,819 patients had been dealt with, 677 being in-door patients, 1,089 out-door patients, and 153 in the Benevolent Asylum. The daily average was 133 $\frac{1}{2}$. The rate of mortality in all cases was 6 per cent.; but in hospital cases only 4·09 per cent. The financial statement showed that the receipts, including £3,050 from Government, amounted to £5,036 14s. 1d., and the expenditure to £5,106 12s. 4d.

A CLASS in connection with the St. John's Ambulance Association has been formed at the Spencer-street railway station, Melbourne. Some 70 or 80 railway employés who have signified their intention of joining it will receive instruction from Dr. R. Robertson. It is intended to establish a second class at Flinders-street station at an early date.

THE outbreak of typhoid fever in Victoria is becoming a matter of serious concern. Within the last few weeks no fewer than 196 cases have been reported to the Central Board of Health, of which 36 have proved fatal. It is a well-known fact, too, that many cases are not reported. The outbreak is not confined to any particular district or districts, but cases have been reported from all parts of the colony.

JOHN FULFORD, M.R.C.S., Eng. 1877, L et L Mid. R.C.P. Edin., 1880, public vaccinator and health officer of shires of Mt. Rouse and Mintamite, died at Penshurst on January 22, at the early age of 30 years. The deceased gentleman was a surgeon of the Red Cross Society during the Russo-Turkish war in 1877-78.

DR. P. D. BRAY has commenced practice at Williams-town.

DR. HALFORD, jun., has settled at Beaconsfield, a railway township 28 miles E. of Melbourne.

MR. J. B. KIRKLAND has been elected demonstrator of chemistry, and Mr. J. W. Barrett, M.B., demonstrator

of physiology and histology, at the University of Melbourne.

DR. A. PLUMMER, of Port Melbourne, has been appointed to represent the agricultural interest at the Melbourne Centennial Exhibition.

WESTERN AUSTRALIA.

DR. J. A. LANGDON, formerly of Brunnerton, Westland, N. Z., has been temporarily appointed District Medical Officer for the Kimberley Goldfield Magisterial District.

MEDICAL APPOINTMENTS.

Allen, William Robert, L.R.C.P. & R.C.S. Edin., to be Health Officer for shire of Creswick, Vic., vice Dr. R. C. Lindsay.
 Baker, George Wiston, M.D. & Ch.M. Toronto, L.R.C.P. & R.C.S. Edin., elected Medical Officer to the Temora Hospital, N.S.W.
 Coane, James, L.R.C.P. Edin., L.R.C.S. Irel., to be Surgeon of the Victorian Mounted Rifles.
 Cuscaden, George, L.R.C.P. & R.C.S. Edin., to be Government Medical Officer and Vaccinator for the district of Urana, N.S.W.
 Freeland, Andrew, M.D. & Ch.M. Glas., to be Government Medical Officer and Vaccinator for the district of Gundagai, N.S.W.
 Moore, Thomas Dawson, L.R.C.S. Irel., to be Public Vaccinator for Queenscliffe, Vic., vice Dr. W. Scott, resigned.
 Newman, Dewitt Clinton, M.D., to be Government Medical Officer and Public Vaccinator for the district of Cobar, N.S.W.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Nash, Andrew William, M.B. & Ch.M. Edin., 1886.
 Mitchell, Adam Garratt, L.R.C.P. Edin., 1880; L.R.C.S. Edin., 1880.
 Hunter, George Holbrey, L.S.A. Lond., 1885; M.R.C.S. Eng., 1885.
 O'Neill, Gregory John Lamb, M.B. & Ch.M. Edin., 1886.
 Forbes, Henry Farquharson, M.B. & M.S. Aberd., 1886.
 Finlay, Sinclair, L. & L.Mid. K.Q.C.P. Irel., 1884; L.R.C.S. Irel., 1883.
 Fjeldstad, Axel Hieronymus, M.D. Christiania, 1885.
 Bohrsmann, Christian, M.R.C.S. Eng., 1886; L.R.C.P. Lond., 1886.
 Ludlow, Victor Elthelbert, L.R.C.S. Irel., 1886; L. & L.Mid. K.Q.C.P. Irel., 1886.
 Semple, Miller, M.B. & M.S. Glas., 1884.
 Wade, Thomas Fowler, L.R.C.S. Irel., 1885; L.K.Q.C.P. Irel., 1886.
 Rankin, Richard Power, L.R.C.P. Edin., 1886; L.R.C.S. Edin., 1885.

NEW ZEALAND.

McNeill, John Patrick, B.A., M.D. Dub.; L. & L.Mid. R.C.S. Irel.
 Harris, Stewart Hall, L. & L.Mid. K.Q.C.P. Irel.; L.R.C.S.I.
 Ewart, John, M.D., M.B. & Ch.M. Edin.
 McIver, William, M.D. & L.Mid. Roy. Univ. Irel.; L. & L.Mid. R.C.P. & R.C.S. Edin.

QUEENSLAND.

Brannigan, Henry Cooke, M.D. & Ch.M. Roy. Univ. Irel., 1883; L.R.C.P. & R.C.S. Edin., 1877.
 Milne, James, M.B. & Ch.M. Edin., 1883.

VICTORIA.

Trumpy, David, Staats Examen, 1879; M.D. Zurich, 1880.
 Williams, Ezra Hurlburt, L.R.C.P. Lond., 1884.
 Grant, Andrew, M.B. & Ch.M. Aberd., 1884.
 Seelenmeyer, Adolphe Frederick, M.D. Brussels, 1885; L. & L.Mid. R.C.P. & R.C.S. Edin., 1885.
 Bray, Percy Dean, M.R.C.S. Eng., 1885; L.S.A. Lond., 1884.
 Jones, Walter William Stockton, L.R.C.S. Irel., 1881; L. & L.Mid. K.Q.C.P. Irel., 1881.
 Halford, George James Archibald Billing, M.B. Melb., 1886.
 Reid, John, M.B. & Ch.M., 1882; M.D., 1886 Aberd.

REPORTED MORTALITY FOR THE MONTH OF DECEMBER, 1886.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
					Measles.	Scarlet Fever.	Group and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.
N. S. WALES.												
Sydney	125,000	292	203	113	...	1	4	6	6	16	13	9
Suburbs	175,000	732	464	313	...	10	4	12	19	74	27	17
NEW ZEALAND.												
Auckland	33,161	79	35	18	...	...	...	...	5	2	2	1
Christchurch.....	15,266	29	14	5	...	...	...	...	...	2	1	...
Dunedin	23,243	46	16	4	...	...	...	...	...	2	2	3
Wellington	25,945	88	23	8	...	...	...	1	...	4	1	...
QUEENSLAND.												
Brisbane	32,571	104	35	20	2	3	...	10	4	7	3	...
Suburbs	19,112	65	50	18	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.	318,740	779	424	213	2	12	7	20	59	27	20	11
Adelaide	45,333	108	101	42	...	1	1	6	17	10	2	4
TASMANIA.												
Hobart	30,516	99	46	25	...	1	1	2	5	3	5	3
Launceston.....	19,007	52	20	12	...	1	1	1	6	4	1	1
Hospitals, Asylums, Gaols, &c. .	1,231	...	39	...	...	...	...	...	...	...	...	...
Country Districts.	86,404	236	75	...	...	2	1	...	6	...	...	...
VICTORIA.												
Melbourne	69,774	122	117	384	1	1	6	10	26	130	67	28
Suburbs	275,606	920	649	...	...	...	...	...	...	...	...	...

METEOROLOGICAL OBSERVATIONS FOR DECEMBER, 1886.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	Inches	Rain.	Days.	Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Depth.						
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	102.3	71.4	46.9	29.834	...	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	146	78	63.4	49	...	250	5	67	...	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	151	92	76	55	29.952	2.15	14	67	...	...	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	158.9	88.8	58.8	33.8	...	1.742	9	66	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	146	79	57.1	38	...	3.412	15	70	...	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	91	60.8	38.3	29.914	.75	10	76	...	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	...	84	63.9	40	29.957	2.25	7	68	...	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	...	96.8	63.4	46.7	29.889	3.54	10	69	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.....	...	87.1	69.2	52.8	29.994	4.34	15	69	69	S.E.	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	141	76	58.6	41	...	1.454	8	76	...	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

CASES OF HYDATID DISEASE.

READ BEFORE THE MEDICAL SECTION OF THE ROYAL SOCIETY OF N.S.W.

By ALFRED SHEWEN, M.D., LOND., SENIOR PHYSICIAN PRINCE ALFRED HOSPITAL, SYDNEY.

I PURPOSE in this paper to lay before you some particulars with regard to some of the most interesting cases of hydatid disease which have occurred in Prince Alfred Hospital since its opening about 4 years ago. I am well aware that this subject of hydatids has been worn nearly threadbare, but at the same time we cannot but remember that this disease is most constantly with us, and produces an immense amount of suffering in this and other colonies. This then must be my excuse for bringing this subject once more before you.

I find that we have had in all, during the past four years, 44 cases of hydatid disease within the wards of the Alfred Hospital. In 12 of these the disease has been connected with the abdomen as distinguished from the liver, in 1 the tumour was found in the muscular tissue of the thigh, in 4 the parasite had attacked the lung, and in 27 cases it had singled out the liver as its site of growth. This would give us a per-cent-age of about 60 for the liver, 27 for the abdomen, and 9 for the lungs.

Amongst these 44 cases there are some which have presented special points of interest; these I shall now do my best to lay before you.

One of the most interesting of the abdominal cases was that of G. S., a cabman, admitted into the wards on the 3rd March, 1886. He had been suffering for two years with a swelling in his abdomen, which was getting larger every day. On admission it was found that he had a dull, fluctuating, elastic tumour, about the size of a child's head at term, situated below the liver but separate from it, and encroaching on the median line. The exploratory syringe revealed the presence of pus, but various attempts to relieve the sac of its contents by means of the aspirator were futile, owing to the canula becoming blocked; so on the 25th March, I made an incision over the cyst, about 2 inches below the margin of the ribs, dividing the fibres of the rectus muscle—the danger of a leakage into the peritoneal cavity

having been previously provided against by sewing the sac securely to the abdominal wall. An opening sufficient to admit the forefinger was made in the sac and about 3 pints of puriform hydatid fluid were evacuated. The cavity was well washed out with warm water, several cysts having to be helped out by means of the finger, and finally it was washed out with a weak solution of iodine, and a very large drainage tube was left in. The washing out was kept up night and morning until the cavity was completely closed. He made an uninterrupted recovery, and was discharged on the 17th of April, about 3 weeks after the operation. Nothing has been heard of him since, though I have seen him several times on his cab in the street; so I presume that there could have been but one cyst in his abdominal cavity. I felt some anxiety in this case as to the best mode of cutting off the peritoneum from the incision, for the tumour seemed to be quite free within the abdomen, and I do not know that I could have adopted a better mode of doing this than by sewing the sac to the abdominal wall; at all events it appeared to bring about the desired result. The operation was done in this way: The abdominal wall was pressed inwards by the hands until it was felt that that structure and the sac-wall were lying flat against one another, a curved needle threaded with silk was then pushed into the sack and brought out again so as to include about $\frac{1}{2}$ an inch of sac and abdominal wall, and the two ends of the thread were tied tightly together. Six of these stitches were made and a portion of the abdominal wall and cyst was isolated so that an incision about $1\frac{1}{2}$ inches in length could be made with absolute safety as regards the peritoneum. I had intended to delay the incision for a day or two in order to allow adhesion to take place, but as the necessity for making an opening was somewhat urgent I made the incision immediately I had finished the stitches. There is an advantage in this mode of securing the peritoneum, which is, that one knows exactly how large an incision may be made with safety. I am of opinion that when it is necessary to make a free opening into a hydatid cyst, it is of great advantage to make one large enough to admit the forefinger, so that the cyst may be emptied of its contents at once; for nothing becomes fetid more rapidly than the contents of a hydatid cyst, and it is astonishing how very contracted, however big it may be at first, the opening becomes after a few days, and how very much more difficult it is to get out any small cysts which may be left behind two or three days after the operation. It is necessary to keep a very

large drainage tube in if we wish to be able to introduce the forefinger a day or two after the incision.

The next case I will draw your attention to is that of a child from the Manning River, aged 11. She was sent into the hospital in a state of extreme emaciation and hectic; so low was she that we felt some doubt whether it was advisable to attempt to do anything for her. The hospital notes say that she was admitted on the 28th January, 1886, suffering from a swelling in the region of the liver. Dulness on percussion extended from the 3rd rib to $1\frac{1}{2}$ inches below the umbilicus. The swelling had been noticed for 3 months. To the hand it was doubtfully fluctuating. The exploratory syringe gave thin pus. Temperature, 101° F.

On the day after her admission I made an incision at the 8th interspace in the axillary line and about 6 pints of puriform hydatid fluid were evacuated, the later portion of which was mixed with bile. The finger passed into a large cavity within the liver. Washing out was carefully performed twice daily. Some 10 days after the operation great faintness and hiccough were caused by syringing the cavity, and some few days subsequently unconsciousness, squinting, rigidity of limbs took place. This did not, however, occur subsequently, and it was my impression that it had been brought about by the cavity having been distended in the endeavour to measure its capacity. The patient did pretty well after this for some few weeks, although the upper line of dulness to the 3rd rib still remained as before, and the temperature fluctuated more than it should do. On an exploratory syringe being used at the angle of the scapula we got pus. It was evident, therefore, that we had to do with pus in the pleura as well as in the liver. On the 25th March, Dr. McCormick was kind enough to resect a portion of a rib below the angle of the scapula and establish a free opening into the cavity of the chest. A quantity of foetid puriform hydatid fluid escaped, and on an examination being made with the finger no communication with the opening into the liver was to be found, nor did fluid injected pass from one cavity into the other. From this time the patient did extremely well, the temperature fell to the normal, the appetite returned and emaciation disappeared. She was discharged on the 29th of April, 3 months after her admission, with her right chest very much shrunken, but otherwise as well as ever. I have heard since that she has got quite well and hearty.

This was a case which presented some points of interest. I dare say it will be wondered why, with a tumour reaching downwards $1\frac{1}{2}$ inches below the umbilicus, I should have made my

incision so high up, viz., at the 8th interspace, instead of choosing the usual place just below the margin of the ribs. My main reason for doing so was that I might get into the liver as high up as I possibly could without opening the pleura, for in my opinion it is of great importance in all such cases to make our opening as near the upper boundary of cyst as is consistent with safety, for contraction always take place upwards, and if we do not have our drainage tube at the top, when the filling up of the cavity occurs, we find that there is an awkward space left which takes a very long time to fill up. I am aware that there is an objection to going between the ribs, but I found no difficulty in passing my forefinger its whole length into the cavity, and washing out was performed without any difficulty. The question naturally arises in one's mind whether in opening the liver in this manner I did not at the same time lay open the pleura and give rise to subsequent pleurisy. I am of opinion that the history of the case contradicts this, for we must bear in mind that on admission the dulness reached from the 3rd rib downwards, and that this dulness was unaffected by the withdrawal of the 6 pints of pus. What then was the real state of things on admission? If the liver was pushed up by the enormous hydatid below, as we supposed when she came into the wards, why when all that fluid had been withdrawn did not the line of dulness sink? Or again, if, as may be argued, we by the incision made the cavity in the liver and that of the pleura communicate one with the other, and thus allowed the hydatid fluid to flow into the pleural cavity, why, I say, should not one cavity have been drained by the drainage tube just as much as the other? But the strong point in favour of the pleural cavity having been unaffected by the incision is that the upper line of dulness remained as before after the operation. The fluid above the diaphragm was undoubtedly hydatid, but whether it was inside or outside the lung is uncertain.

The next case I have to bring before you is that of a huge cyst of the liver, the largest I have ever seen.

J. H., a labourer, aged 43, from Bourke, was admitted into the hospital on the 23rd September, 1886. He had enjoyed good health up to 3 months ago, when he noticed that his wind was getting short and that he had a difficulty in stooping. On admission it was found that the whole of his abdomen was occupied by a semi-fluctuating mass, with a continued line of dulness from the 4th rib on the right side downwards to the groin; the dulness extended into the right flank, in fact the whole abdomen from the costal margins to groin was absolutely dull on percussion,

with the exception of the extreme left flank, where the note was tympanitic. With this immense area of dulness there was no undue prominence anywhere; the right costal cartilages were not bulged, nor was there anything prominent to be felt on palpation. Judged by the eye alone one would have guessed that the patient was suffering from an abdomen half full of ascitic fluid. He measured 87 inches in circumference at the umbilicus. The exploratory syringe gave us hydatid fluid below the umbilicus and at the costal cartilages. We came to the conclusion that he was suffering from a huge hydatid cyst, probably taking its origin in the liver, so on the day after his admission Dr. McCormick was kind enough to make a free incision below the margin of the ribs, and about 33 pints of purulent hydatid fluid containing hundreds of free cysts of all sizes were evacuated. The fluid was quite sweet. Sheets of lining membrane $\frac{1}{2}$ an inch thick came away in great quantities towards the end of the washing out process. The cavity was washed out time after time until the fluid returned clear and free from cysts, and finally it was washed out with a weak solution of iodine. Two of the largest size drainage tubes, each with a lumen of $\frac{1}{2}$ an inch, were laid in side by side, and a bird's nest of tenax was applied over the whole. During the week following the operation the cavity was washed out twice daily and afterwards once daily with a weak solution of iodine. During the course of recovery the patient had now and then some rise of temperature; once it went up to 104° F. with considerable abdominal tenderness, but the discharge always remained sweet; on the whole he did very well. There is now still a considerable cavity towards the back of the liver, but the great bag downwards is pretty well closed, for neither finger nor probe can be passed more than 2 inches in that direction. He is making flesh and his appetite is good. We contemplate sending him to the Convalescent Hospital at Little Bay in a day or two.

The chief points of interest in this case were the immense size of the cyst and its shape. In hydatid of the liver with enlargement downwards we almost invariably find a bulging of the lower ribs, but in this case there was none at all; there was such an absolute want of prominence in any one spot, that we could hardly believe that we had to do with a cyst in the liver at all. This case also illustrates my previous remark as to the importance of making our opening as high as possible. We found that the cavity contracted from below with immense rapidity and that the only practical difficulty in closing up lay in that portion of the cyst which occupied the upper posterior portion of the liver.

ON THE REMEDIAL EFFECTS OF THE PRIEST'S BATH AT ROTORUA (N.Z.) IN CASES OF SPINAL PARALYSIS.

By J. S. CARO, M.D., MEDICAL OFFICER
HAWKE'S BAY CHARITY AID BOARD, NAPIER,
NEW ZEALAND.

Mrs. C., a dentist of Napier, was taken ill on 6th March, 1886. After a few days of malaise characterised by excessive debility, moderate pyrexia, and slight rigors, her disease assumed the form of remittent fever in its gravest aspect, which, the patient then residing at the foot of a hill, was considered by her medical adviser, Dr. Spencer, as a paroxysmal fever of a malarial origin. She had to keep her bed for over six weeks, and only very gradually improved under treatment by quinine, quinetum, arsenic, &c. On becoming convalescent, the patient found herself totally unable to put her feet to the ground; she could neither walk nor stand, and any voluntary motion caused her a certain amount of pain. On a certain spot in the lumber region of the spine she felt great tenderness at the mere touch; she suffered also occasionally from severe headaches and nausea, and even vomiting occurred at times. At first, and for a few weeks after, the patient was completely palsied, and she could only move on her elbows and knees, but gradually some improvement in the motor power took place, and in the course of a month she was able to walk with the aid of crutches. The functions of the bladder and rectum were not interfered with. The temperature of the affected limbs was much lowered, but their muscles, though somewhat flaccid, did not exhibit any signs of degenerative atrophy, nor was the nutrition of the skin anywhere impaired. The electrical reactions were at first quite abolished, as the muscles of the legs did not respond either to the faradic current or even to the voltaic, but later on they commenced to become influenced by both kinds of currents, and at last the electrical conditions got quite normal. The treatment adopted by her medical attendant was to put her upon a nutritious diet with a small allowance of stimulants and the exhibition of drugs considered appropriate remedies in certain spinal affections, such as small doses of strychnia, combinations of iron and arsenic, and occasional applications of counter-irritants to the tender spot in the back. After nine months' treatment, the patient's limbs, though somewhat improved, had still not regained their freedom of movement, and a permanent paresis was apprehended. As a last resource it was decided to send her to the sanatorium at Rotorua,

and to place her under the skilful care of its superintendent, Dr. Ginders, and I am happy to state that the favourable results exceeded by far our expectations. Whereas on arrival there the patient was utterly powerless to move her limbs without assistance, after a four weeks' steady course of baths in the Priest's Bath and the daily application of the galvanic battery, she was able to use her limbs freely, and to throw away her crutches altogether. Finally, after a residence of six weeks in the thermal region of Rotorua, she returned home completely cured, with the powers of locomotion perfectly restored. In reporting the above case I am at a loss to point out the true nature of the affection that caused the paraplegia. It could not have been myelitis, as there was no loss of control over bladder or rectum, and several other prominent symptoms indicative of inflammation or structural defects in the substance of the cord were entirely absent; nor do I think it possible that the bathing in an aluminous and strongly acid bath would have regenerated diseased nerve-cells. There were, furthermore, no marked signs of any of the other varieties of spinal-cord disease described in clinical literature. The affection the above case bore most resemblance to is the one described by Duchenne, under the name of "Paralysie spinale atrophique aiguë." But then again, the case under consideration differed materially from Duchenne's "Poliomyelitis anterior acuta," by its not having involved the upper extremities and by its having been a paralysis without wasting of any muscles or groups of muscles. Possibly the disease in question may have been a limited meningitis spinalis, involving only a segment of the lower meninges of the cord, which would account for the absence of many symptoms characteristic of meningeal inflammation of the spine.

Anyhow, whatever the pathological process antecedent to the paralysis may have been, the latter was certainly a most obstinate one, and yielded to none of the remedies usually resorted to in paraplegia; and only the month's trial of the above-mentioned bath, aided by electricity, proved effectual, and enabled the patient to dispense with artificial assistance and to leave Rotorua with her health completely recovered.

REMARKS: A strange phenomenon in the above rather remarkable case was an effusion into the bursae of the big toes, which caused great pain and considerable swelling. These were relieved by rest, fomentations, and poultices. But even after the application of iodine paint and frequent blistering, the walls of the bursae remained callous and hypertrophied, so as to form almost solid tumours. No excision and enucleation of the

sacs were performed, owing to the patient's delicate state of health leading to the apprehension of inflammation of an erysipelatous character setting in. These tumours have become entirely absorbed under the treatment at the baths.

A CASE OF RENAL CALCULUS.

READ BEFORE THE S.A. BRANCH, B.M.A.,

By L. W. BICKLE, M.R.C.S., Mt. BARKER, S.A.

I AM induced to bring this case before the Society for the following reasons:—1st. That a stone of so small a size, weighing only two grains, should have taken six days to pass from kidney to bladder. 2nd. That the nature of the stone was diagnosed by the microscopical examination of the urine, this allowing one to lead the patient's friends to expect a protracted period of suffering. 3rd. The fortunate issue of the case, the stone being passed almost without pain in less than twenty-four hours after it had reached the bladder.

The symptoms were very typical and strongly marked. The patient, a short, fair woman, about 40 years of age, had had occasional attacks of pain in the left side, which were usually attributed to "wind," and for these no advice was sought. On the night of Oct. 1st she went to bed in her usual health, and woke up a few minutes after going to sleep in violent pain, having first experienced a sensation of falling down a precipice. I found her rolling on the floor in agony, with a constant desire to micturate, and passing only a few drops of clear urine. The body was cold, the pulse small and contracted. There was intense pain in the left side, with marked local tenderness over the region of the left kidney. The pain went down to the groin, and to the labium, and also down the thigh. She was also sick, and the breathing was very shallow and rapid, anything like a deep inspiration causing excessive pain. There was an increase of temperature.

I gave a hypodermic injection of morphia, and applied hot fomentations. About $\frac{2}{3}$ of a grain were given in two injections, and then the pain began to moderate.

The diagnosis was easy; there was of course the possibility of it being pleurisy or pleuro-pneumonia, but the absence of cough and fever and the position of the pain, together with breath sounds clear to the extreme base, excluded these.

Colic or intestinal trouble were excluded by a history of regular action of bowels and a clean tongue, despite the sickness. As the patient attributed her illness to over-lifting, the possibility of retroversion of the gravid uterus came in, but

the menses were regular and there was no tenesmus.

After the pain subsided, urine was passed freely. Some of this I examined—it was clear, no cloudiness or sediment ;—there was no albumen. On examining with the microscope, numbers of crystals of oxalate of lime were found, and much epithelial debris. This clinched the diagnosis, and enabled me to give a prognosis of probably many recurrent attacks of pain until the stone reached the bladder. Later the urine was somewhat clouded. For two or three days there were frequent attacks of pain, which had to be controlled by morphia. Alkalies, and opium with tincture of belladonna were given by the mouth. The local tenderness remained in the same spot till the Wednesday morning (*i.e.*, four days). On that day I found it quite three fingers' breadths lower down, and the patient was able to press on the spot herself. The same evening the stone had made further progress, as the back was free, but there was marked tenderness about the brim of the pelvis on palpating the abdomen. As the bowels had become a little constipated they were opened by enemata, and some time after this the patient experienced great relief, the stone having reached the bladder. About twelve hours after, “a peculiar fluttering feeling” was felt, and on making water the calculus was passed. It will be seen to be a small rough mulberry stone, evidently of slow growth. On the border surface numerous small fresh additions are noticeable. These were doubtless formed during the stay in the ureter.

The chief point in the treatment noticeable was the relief felt by exhibiting the citrate of potash instead of the bicarbonate, which I used at first. On the third day I changed it to the citrate, the thirst being greatly relieved. The attacks necessitated the very free use of morphia, and this leads me to notice one point in the hypodermic use of the drug of interest, although it is probably generally acted upon. In these and other cases of severe pain the pulse is always small, hard and incompressible ; it may be quickened at first by the injection, but as soon as the sedative influence begins we get a marked and sudden change, the tension being suddenly lowered—the pulse, as it were, falls away from the finger and then becomes soft and full. This may often be noticed before the patient actually experiences the relief which can then be confidently predicted, but of this one may be sure, that, if the change occurs, the dose given will prove sufficient, the relief will follow in a very short time. It is something like the flash from a gun fired at a distance, the report seems to come a long while after—here one may feel the influence of the drug before the patient is actually aware of it.

RICINUS COMMUNIS.

By THOMAS DIXSON, M.B., C.M., LECTURER UPON MATERIA MEDICA, UNIVERSITY OF SYDNEY.

THE oil from the seeds of the above plant has been used medicinally from very ancient times (*Herodotus*). Like many other remedies, it seems to have passed very much out of use till its revival in the middle of last century. Probably, no remedy has been subjected to more thorough and persistent investigation ; yet to this day the nature of the active principle causing the action this drug is unknown.

The following article purposes giving a very short resumé of the present position of the question, and a condensed account of the investigation made by the author of this paper at the Pharmaceutical Laboratory at Strassburg, at the suggestion of Professor Schmiedeberg, the Director.

As regards the solitary species of *Ricinus Communis*, it seems that there are many minor differences distinguishing the specimens grown in various countries, so that even the seeds vary much as regards size, colour, &c. ; but the oil produced seems to be very uniform, so far as can be ascertained.

Aside from the aperient action of the oil, the seeds have been known to have a purgative action when taken in very small amounts ; many deaths having been due to unwise use of them for medicinal purposes.

As a specimen of the effects of eating these seeds, Dr. Rapp (*Recueils de Mem. de Med., &c., Militaire* ; Oct., 1870) gives the following case :—A soldier ate 17 seeds for an aperient effect. In 3 or 4 hours violent diarrhoea came on, with a burning, crampy feeling in the stomach, and nausea, followed by vomiting. In the vomit were the remains of seeds and also oil-drops. The diarrhoea became more frequent, watery, and copious, but there was no griping nor colic. The man sent for the doctor because of the cramps, chilliness, and diarrhoea. He received two grammes of ipecacuanha. About 12 hours afterwards his face was anxious, covered with cold perspiration, his eyes were upturned, conjunctivæ infected, tears flowing, pupil moderately widely dilated ; while painful cramps attacked the muscles of the limbs and trunk. The pulse was very small, but regular ; mind clear ; there was headache, giddiness, buzzing in the ears, also great thirst, pre-

cordial anxiety, feeling of constriction in the bowel. The vomit became quite fluid, bilious, and full of gelatinous threads, the stools being very choleraic. Anuria now was noticed, and the patient became very prostrated. As he had probably vomited the poison, or otherwise got rid of it, the treatment was to warm him, give anti-spasmodics, and warm drinks (but the latter made him worse). Under this the cramp soon left, the temperature rose, the circulation improved; but the vomiting lasted till the morning of the next day, when the diarrhoea, pain in the belly, weakness, and anuria lessened, while feverishness supervened. In six days the diarrhoea had quite left off. The urine, after the first day, was dark, albuminous, and dense. The treatment consisted in mallow clysters, mucilaginous lemon drinks, rhubarb, opium, and meat broths. In ten days he was dismissed.

In another case, gangrene of one foot, necessitating amputation, accompanied symptoms similar to the above. Other cases are described in various journals, &c., e.g., by Cameron, Orfila, Soubeiran, Mialhé, Berguis, and others.

Popp (Archiv. Pharm. (2) cxlii, p 143), states that 6 unripe seeds cause violent diarrhoea lasting 3 days, with vomiting, cold sweats, &c., and that the unripe are more energetic than the ripe seeds.*

Pecholier remarks that in no case of poisoning was pain in the throat complained of, the taste being *liked* rather than otherwise; that there results, 1st indigestion, 2nd gastro-enteritis, 3rd ataxia and adynamia. He imagines that the principle is formed gradually, for it is slow to cause the symptoms. He believes that the cold-pressed oil, although of a better taste, is not nearly so efficient as the oil got by pressure with warmth, for it often fails after 20 grammes doses.

Parola recommends the oil extracted from the seeds by alcohol and ether, for it keeps better, does not cause vomiting nor nausea, and is 4 times as strong as the oil got by cold pressure. Demaria also prefers an alcohol-extracted oil made thus:—"Clear the shells off carefully, bruise them in a mortar with alcohol, at 86° C., to a porridge-like mass. Expose for 2 to 8 days at a temperature of 20° C. Pass through a cloth in a press, and let stand 24 hours in a cool place; thus two layers form, a lower of resinous oil, and an upper of alcohol with castor oil in solution. The oil so got is less thick than the ordinary, has no bad taste, no action on test paper. It contained no alcohol, and could be got to the extent of half as much by weight as was used of seeds. Such an oil never caused vomiting nor nausea and but seldom irritation of the bowels."

As to the origin of the activity of the oil, we find the following suggestions:—

1. Buchheim (Ueber die scharfen Stoffe) thought that it was not the Ricinoleic acid, but an impurity, which causes the aperient action of the oil.

2. Soubeiran thinks the action of the oil due to a resin (which has not been isolated).

3. Saalmüller thinks it due to Ricinoleic acid.

4. Bübnow (Schmiedeberg's Arzneimittelrehe, 1st ed.) thought that the oil extracted some of the active principle from the seeds.

It will be seen that neither of the theories (1) or (2) is likely to be correct, and that (3) and (4) are absolutely not so.

Emil Werner says that, from his researches, he concludes that: 1. The oil has much less poison than the seeds. An emulsion of 4 drs. seeds, contains 1½ drs. of oil, and causes 8 evacuations on a man; but an emulsion of 1 oz. of the oil causes only 4 evacuations. 2. The active principle is insoluble in alcohol, ether, benzin. The residue, after these reagents, acts just as strongly as the seeds before, for ½ oz. purged a medium-sized dog for several days. 3. The substance is soluble in cold water. The cold extract of the seeds, extracted before by alcohol, acts not much less actively than the seeds themselves in corresponding quantity, for 1—2 oz. in 2 ozs. of water, gives a painless, watery stool, and cause vomiting. 4. The substance decomposes, especially in the heat, and hence watery solutions are impossible. 5. From water, 4 volumes of 90 per cent. alcohol can't yield it; nor is acetate of lead of use. 6. *The proceeds of 20 grammes of seeds, evaporated over sulphuric acid, became inert.* 7. It is not a resin. 8. It is in the endosperm and embryo, but not in the shells of the seeds.

These facts are confirmed in the following article in all essentials, and really contain the essence of all yet really known as to the seeds and oil; it is very evident that some of the other authors (Demaria, &c.) have not been sufficiently exact in their details.

Among the chief remaining chemical attempts with the oil and seeds are: 1. Those of Tuson (Bulletin de la Soc. Chim. de Paris, Aout 1866), who by boiling the seeds, after extraction with alcohol, for some days, obtained the crystalline Ricinin, a pharmacologically *inert* substance. 2. Those of Ritthausen, who investigated the albumenoids, &c. (Journal Praktische Chemie, vol. 25, and Pflüger's Archiv. 19); but the answer to the question is not in any way advanced by these latter.

(The Author's investigations on this subject will be published in our next issue.)

* I have had not the opportunity of confirming this.

INTRACRANIAL TUMOURS.

READ BEFORE THE NEWCASTLE (N.S.W.), MEDICAL SOCIETY.

BY JOSEPH STAPLETON, M.B. ET CH.M. EDIN.,
M.R.C.S.E.

THE case that forms the subject of this paper came under my notice in practice during the last few months, and as several of the hospital staff saw it and were anxious to hear the end of it, I will present it to you.

I am sorry to say that it bears the stamp of imperfect preparation, for though we all expected that it would end fatally, I did not think a *post-mortem* would be obtained and its nature disclosed; and moreover, this Society was not then in existence, and I did not calculate upon the honor of being allowed to address you.

But I will give it with as much accuracy as my memory serves me, with as much conciseness as I can command. Not that much practical value from a therapeutic or curative point of view will be gathered from the case, but perhaps it may be the means of helping you to diagnose and plan out the course of a disease and pilot your patient symptomatically to death, and thus impress the friends with your medical acumen, so that they may not fail to seek you in those complaints over which we have control, as was, I believe, clearly and brilliantly shown in the case of Tetanus read before you last month by Dr. Bonnefin.

History.—The boy was aged 10 years, and came over from Victoria about 5 months ago. He was then, to speak alliteratively, strong, stout, and sturdy, and never ailed till the 1st of August of the present year, just 3 months before he died. At that time I was called in to see him, with, as I thought, Dyspepsia, as the symptoms were vomiting, headache, and anorexia, but without any rise in temperature to indicate typhoid fever. I attended a month, when, as he appeared to get better, I discontinued, but in less than a week I had word to call again, as he had become blind in one eye and had had a fit. I rejected the history of the fit, but was obliged to accept the visual defect; and then suspecting something of a cerebral complexion I brought him into the Hospital, where several of you saw him and noticed the dilated pupils, the blind eye, the ataxic state, or perhaps condition of vertigo when he was made to stand up. You will remember also that he referred his pain to the occiput. At your suggestion I used the ophthalmoscope, and though I now believe there was an optic neuritis I did not then succeed in discovering it. But the most interesting feature was found afterwards in testing

his vision in the left eye. At one time he could see my fingers when held up, while at another he registered his inability to do so. This state of hemiopia (it was temporal) continued for some time, and then the eye went blind. Whether this was the case with the right eye I am unable to say, as the vision was gone before my attention was called to it. The complete blindness continued, the pupils kept dilated and could not be moved under any influence, the pain left the back of the head and settled in the temples until he died suddenly one evening, just about three months from the beginning of his illness.

Post-mortem.—I made a *post-mortem* which was very satisfactory, inasmuch as the diseased condition was found at a site which will readily harmonise with the leading symptoms in the case. There was a tumour—what it was will be considered further on—pressing upon the chiasma and both optic nerves.

Such is the case, and now a few words under separate headings.

It was a well-marked case from a symptomatic point of view, as we had

Cerebral vomiting,
Headache,
Convulsions,
Ataxia or vertigo,
Optic neuritis.

Vomiting.—This is often a very important symptom of cerebral disease, and an organic lesion in any part of the brain will cause it. It is a reflex act, and is due to an exalted excitability of the gastric centre. Here, then, in the case to which I have invited your attention, we have set up some subtle, dynamical change in the medullar centre, through a disease located on optic nerves and chiasma, and vomiting is the result.

Headache is a conspicuous symptom of tumour of the brain, and is characterised by its severity and constancy; the latter was well illustrated in this case as it persisted all through either in the occiput or temples, but on the other hand it was never severe enough to require a single dose of bromide of potassium to ease the pain. It is associated with vomiting and optic neuritis according to Gowers, who says that if there is persistent headache and optic neuritis you may put it down to tumour, unless there is an abscess to explain the symptoms.

Convulsions are common in brain tumour, but are only slight and partial, so that I really believe that the fit the parents spoke of was one, though I rejected it at the time they made the statement.

Ataxia or Vertigo.—Whether it was the one or the other that was disclosed in his inco-ordination when made to stand up or walk I am not prepared

to say. My own opinion is that it was due to the defect in his vision which made him so insecure upon his feet.

Optic Neuritis—or to be more exact and expressive, *Papillitis*—is the result of disease beyond the eye, and may be caused by tumour in brain, or by any other affection within the skull which produces pressure on the nerve or impedes the return of blood through the ophthalmic vein to the cavernous sinus. How the hemiopia resulted will be better seen by referring to the diagrams in the works of Grainger Stewart, and Gowers, than by an explanation I could venture to offer.

Diagnosis.—In this case an anatomical diagnosis, or the site of the diseased condition in the anterior fossa of the skull was not beset with much difficulty, and could have been arrived at if we took into account that all basal diseases chiefly interfere with the cranial nerves, and that when total blindness resulted, the chiasma and both optic nerves must have had their functions annulled.

Pathology.—In reading through Gowers on this subject, I have reduced the possibilities to three.

- I. Distended Third Ventricle.
- II. Myxoma or Degenerated Glioma.
- III. Hydatid.

Distended Third Ventricle.—I have put this down first because that appears to me what it was. About half an ounce of fluid trickled out when the sac was opened, and the soft and friable nature of the covering seemed to me more in keeping with brain tissue than anything else. There was a history of sunstroke, I should have said, and though I looked upon this as more than a ready diagnostic refuge to the unknown physician, I did not think of any change it may have produced in the ependyma ventriculi.

Glioma—or its *Degenerative Condition Myxoma*—is characterised by its tendency to invade and infiltrate the brain tissue, and as there was no evidence of this, I did not think it was probable.

Hydatid has a firm, yellowish and vascular capsule, the result of the proliferation of cellular tissue from irritation, and as this was out of the question, I merely mention it as a remote possibility.

The nature of a brain lesion, pathologically, is the central idea—the kernel for which to crack; for it cannot be gainsaid to be fraught with interest when we know that upon this depends the treatment. But suppose we assign it a place in brain neoplasms, one of the last British medical journals is worthy of being quoted. There, Guy's Hospital reports state that out of 100 cases only 15 were amenable to treatment; and Strahan, writing on the Medical spirit in Asylums, freely

admits (and it would be hard to contradict it in the face of the above statistics) that there is a big future before brain surgery.

In the discussion which followed, Dr. Morgan said his experience would lead him to believe that the case was one of cysticercus of the brain.

CASE OF ACCIDENTAL VACCINIA.

READ BEFORE THE S.A. BRANCH, B.M. ASSOCIATION,

BY JAMES T. MITCHELL, M.D.

C.B., set. 2 years, was first seen by me on August 11th. He was suffering from a vesicular rash, extending over large areas of the limbs and body. Had been vaccinated unsuccessfully when six months old, but the failure was probably due to the quality of the lymph. Ever since he was three months old he had suffered from eczema of the face, limbs, and body in a greater or less degree. Latterly the eczema was almost entirely confined to the limbs in the neighbourhood of the elbows and knees. Five or six days before I was called in, the eczematous patches began to inflame, and in a few hours distinct nodules could be felt. These gradually increased in size, and developed a vesicular character, all being in about the same stage of development. On the 11th inst., I had no difficulty in deciding as to the nature of the disease, as each pock was well shaped, and as nearly as possible mature. On the right leg the vesicles were discrete, but on the left leg they were confluent into large masses 4 or 5 inches across. Very many groups of vesicles were scattered over the body and arms, the groups containing from 8 to 20 marks each. Altogether I estimated the number of vesicles at about 400, every one well marked, umbilicated, mature, and of rather larger size than the ordinary vaccination pock. The constitutional disturbance in the child was not very marked. The temperature rose to 101 deg., and he was listless, cared little for food, and cried on being moved, in consequence of the enlarged glands in axilla and groin. Pustulation followed with no more than ordinary areolar inflammation, and the poxes faded away by about the fourth week, leaving scars in many places, but not so well marked as I had expected. The eczema is, for the time, decidedly better, but time only can show whether it will return to its former degree of intensity. I endeavoured to obtain photographs of the limbs, but, owing to accident, the negatives were spoilt.

In connection with this case it is interesting to note that on July 9th I had vaccinated the infant brother of this child, and the two children played and slept together. No other vaccinated child was near my little patient during the whole time,

so that a period of eighteen days elapsed from the maturity of the infant's arm till the older child became inoculated. I not unfrequently vaccinate a child suffering from eczema, choosing a spot clear away from the eruption, and covering the marks with a wire netting to prevent auto-inoculation until after maturation of the vaccine pocks. After that time there is no danger of the eczematous surfaces taking on vaccinia, even if any lymph came in contact with them.

SUPPURATION OF KNEE JOINT TREATED BY FREE INCISION.— RECOVERY.

BY HARRY TRESIDDER, M.R.C.S.E., L.R.C.P.
LOND., MEDICAL OFFICER TO THE GOVERN-
MENT AND HOSPITAL, COONAMBLE, N. S.
WALES.

PERHAPS the particulars of the following case, occurring in my practice here, may not be without interest to many of the readers of the *A.M.G.* on account of the unusual result attending it.

Harry Harper, aged 33, a native of Fiji, was admitted into Coonamble Hospital on the 15th November, 1884, suffering from Pneumonia of the right lung. About the middle of December his lung symptoms had disappeared, but his temperature was still above normal. Towards the end of the month his left knee became painful, hot, and slightly swelled. These symptoms gradually became more severe until the latter end of February, 1885, when the case fell into my hands. Up to this time the patient had been resting in bed with a temperature above normal, and was extremely weak and emaciated in appearance when I first saw him. The knee presented a fluctuating swelling which was perceptibly hot, and all the symptoms of fluid in the joint. To satisfy myself that the joint was full of pus I pierced it on the inner side, just behind the patella, with an exploratory needle fastened to an ordinary hypodermic syringe, and on drawing the handle the syringe filled with pus. I therefore determined to operate on the patient and give a free exit to the pus. On February the 27th, whilst the patient was under the influence of chloroform, I made two incisions, about 3 inches in length, into the joint, one on each side just behind the patella, and gave exit to about 10 ounces of pus. The joint was washed out with a weak solution of carbolic lotion, and a large-sized drainage tube passed through it behind the patella. The knee was put on a suitable splint, and dressed with lint and carbolic oil, &c. Not being available, neither gauze dressings nor spray

was used. The treatment was continued for six weeks, at the end of which time the wounds were healed and the patient went about on crutches, with a back splint, during daytime. The knee joint was moved forcibly for a short time every day, and the back splint and crutches were gradually left off. The patient was discharged from the hospital on the 29th of May, being able to bend his knee beyond a right angle.

Remarks.—The principal feature of the case is that after pyæmic suppuration of the knee joint the articulation was *movable*, instead of the usually most favourable result, viz., complete ankylosis. I have never seen or heard of any case resulting in this way after suppuration of such an important joint. The man now walks without the *slightest* limp, and can ride almost any horse without the least inconvenience—in fact, he says he can do anything except squat on his heels, which used to be his favourite manner of sitting.

REPORTS OF SOCIETIES.

MEDICAL SOCIETY OF QUEENSLAND.

THE last General Meeting of the above Society was held in Brisbane on Feb. 8th last, at 8.30 p.m.

There were present:—Drs. Bancroft (President), Little, Owens, W. S. Byrne, Webb, Hill, Gibson, McNeely, Hare, Shout, Tilston, O'Doherty, Marks, Thomson and Love (Secretary). Dr. Thorpe, of H.M.S. "Paluma," was present as a visitor.

DR. OWENS shewed an interesting case of cyst of the iris, which was thought by some of the members present to be of a hydatid nature.

DR. THORPE kindly exhibited a microscopic section of the kidney, illustrating Heidenhain's experiment on the excretion of urinary solids by the renal epithelium, and a section of the cochlea, shewing the rods of corti and the hair cells very beautifully.

DR. BANCROFT shewed the pieces of bone removed by trephining from a depressed fracture of the skull.

DR. LOVE shewed a lad in whom the eighth and ninth ribs had been detached from their cartilage.

DR. RYAN, of Gympie, was then elected a member.

A ballot for an additional Council-man, vice DR. LOVE, who had taken on the duties of Secretary, resulted in the election of DR. THOMSON.

DR. F. W. HARE, of the Brisbane Hospital, then read his paper on Typhoid Fever (which will be published in our next issue). Dr. Hare shewed a piece of small intestine with two perforations differing in date.

A desultory discussion followed, which was shared in by DR. BYRNE, LITTLE, WEBB, MCNEELY, TILSTON, THOMSON, MARKS, and the CHAIRMAN.

It was decided to adjourn the discussion till the following meeting, when each member would be invited to give his experience with direct reference to special points which would be brought under his notice by the Council.

After a hearty vote of thanks to DR. HARE for his valuable paper, the meeting terminated.

NEW SOUTH WALES BRANCH OF THE BRITISH
MEDICAL ASSOCIATION.

THE Annual Meeting was held in the Royal Society's Rooms, Sydney, on Friday, 4th March, 1887. Present—Dr. Knaggs (President), in the chair; Drs. Creed, Scot Skirving, Hankins, Wm. Chi-holm, Sydney Jones, Quaife, Fiaschi, Chambers, Clubbe, Bowker, junr., Brady, Lovell, Kendall, Martin, G. A. Marshall, Worrall, O'Reilly, Ellis, Crago, Shewen, Maher, O'Doherty.

The minutes of the previous Annual Meeting were read and confirmed.

The following new members were announced by the President:—Drs. P. Sydney Jones, Graham, McCulloch, Jarvie Hood, Clay, Fisher, and O'Doherty.

The President (Dr. Knaggs) then read the following—

PRESIDENTIAL ADDRESS.

GENTLEMEN.—In resuming once more the meetings of the New South Wales Branch of the British Medical Association, it is with some trepidation that I venture to comply with that custom which imperatively demands that the retiring President should deliver an address. Before entering upon such subjects with which I deem it my duty to trespass upon your good nature, by taking up your time, I wish to express to you how deeply I have grieved over all my shortcomings, as well as how gratefully have I felt the kindly forbearance and graceful support which such of you who have attended our meetings have at all times extended towards me during my term of office. The Report of the Council has placed you in possession of all the particulars of our work during the past session. Nine Council meetings were held, and nine General meetings of the members (of which two were special, two adjourned, and five ordinary). I regret to say that thirteen members resigned during the past year, and, as far as I can judge, these resignations were the outcome of certain unsatisfactory relations which have existed between the parent Society and this Branch. To the same causes may be attributed the fact that no new members were elected during the same period. It is my painful duty to record the loss by death of four members of our Society—Drs. Mackenzie, Bestic, R. D. Jones, and Haughton. By special resolutions letters of condolence were sent to the families of each deceased gentleman. There are now 115 members upon the roll, of which 91 reside in Sydney and its suburbs; 21 belong to the country, and three live in other colonies. The average attendance at the General Meetings amounted to 16 members. The Treasurer reports that we have a balance to our credit in the bank amounting to £207 1s. 6d. The papers which were read, and the discussions that took place, during the meetings of the Branch were of unusual interest. Dr. Hankins read a paper on the removal of a calculus from the female bladder. He also exhibited, and gave a most interesting demonstration, on a case of ankylosis of the shoulder. We were indebted to Dr. Clubbe for exhibiting a case where he had twice operated for thyrotomy, and of which he gave a most instructive clinical history and interesting account of the difficulties which he had to overcome in successfully performing the operation. He also exhibited and demonstrated upon the living subject a case of "Multiple bony growth in a child." To Dr. Crago we are indebted for the relation of a series of cases in which he performed "tracheotomy in diphtheria and croup," with a most extraordinary average of successful results. Dr. Musket read a paper describing "An unusual site for a hydatid cyst." Much interest was excited by a case exhibited

by Dr. Rowling, of Parramatta, of extensive varicose veins which had rapidly developed over the parietes of a middle-aged male subject. A committee subsequently examined the case at his habitation in Parramatta, and a decided opinion arrived at that certain changes were produced by the pressure of a multiple hydatid tumour pressing upon large venous trunks within the thorax. This case is still being carefully observed. To Dr. Chambers we are indebted for several interesting cases, illustrated by careful and elaborate drawings, upon (1) "Umbilical hernia in a female;" (2) "Malignant disease of the kidneys;" (3) "Fibro-cellular disease of the peritoneum." Dr. Chambers purposed reading and discussing an unique case where he performed Cesarean section, under unusual difficulties, but unfortunately the meeting lapsed for want of a quorum. Dr. Worrall read "Notes on a case of extirpation of the uterus," and Dr. Brady contributed two cases of "Rhinitis atrophica." Dr. Martin exhibited a larynx showing papillomatous growth. During two meetings an interesting discussion took place upon "The abuse of narcotics"—a subject which attracted much attention. It was gratifying that at one of the meetings every member present spoke upon the question. The subject of "The examination of seamen in the mercantile marine for normal acuteness of vision and good colour perception" was dealt with during the past session, and a committee was appointed to draw up a memorial to the Government upon that question, but about this time the change of Government and prorogation of Parliament took place, so that it was deemed expedient to let the subject lapse for the time being. When the stirring political strife of the day becomes more settled it is hoped that a further attempt will be made towards a successful issue of this important question. One of the most noteworthy incidents of the past session was a resolution unanimously agreed to by the Branch thanking Dr. Chambers for the stand that he took in defending an action at law most unjustifiably taken against him, and congratulating him upon the successful issue of it in his favour. It was a painful and unsavoury trial, the particulars of which I fully criticised at one of our meetings, showing how liable even the most skilful members of our profession are to unjustifiable and harassing actions at law, without a shadow of reason, when the most consummate skill, caution, and judgment have been used in the examination of a case, at a patient's request. I have the pleasure of congratulating the members upon having successfully passed through a crisis in our history as a branch of the British Medical Association, which at one time bid fair to have terminated in a disastrous collapse. Some of you who were present at our first meeting of the past session, held on 25th June last year, may remember that I touched upon this subject when I was inducted into the presidential chair. I alluded to that meeting as being a critical one in our career. At that time the question was delicately poised as it were in a balance, whether we should sever our connection with the parent society or not. I need not recapitulate the history of that unfortunate misunderstanding. Suffice to say, letters from this branch to the head office in London were disregarded, remittances of money were not acknowledged, lists of new members sent home were overlooked, oral communications by deputies met with inconsiderate attention, money transmitted in payment of subscriptions to the Journal received no attention, Journals were missent, moneys already paid were re-demanded by the home secretary in such a manner as to estrange many of our members from our Branch, and to such a juncture did these extraordinary experiences eventuate that three meetings of our Branch were held to discuss the advisability of severing our connection with the

home Association, and no doubt we would have ultimately attained that undesirable climax, were not a motion to that effect overruled by a technical objection—perhaps improperly so, but most fortunately misunderstood, that no meeting of any Branch could be held with the object of altering its constitution or relationship to the parent society. I feel personally gratified to learn from correspondence lately received from Mr. Fowke, the General Secretary for Europe, that some remarks which I made in allusion to this matter, at our opening meeting, and in hopes of casting oil upon the troubled waters, were partly the means of bringing round a most happy reconciliation and better understanding, as on reading my remarks—quoted in the *Sydney Morning Herald* of June 26 last—he was induced to send us a cablegram asking us to stay our proceeding; in the meanwhile he made full and exhaustive inquiry into the matter that was at issue between us. He then discovered that the trusted official who was the recipient of our correspondence, remittances, and communications had been suffering for some time from cerebral softening—so insidious in its onset that it was not discovered until it had made considerable progress. However, the loss of memory became so manifest that search was made, and then were found—put aside in drawers and various other places—all our neglected correspondence unopened, our uncashed drafts, unopened advices regarding new members, alterations in addresses of old members, and lists of officers annually elected—were all discovered where they all had been placed, and then forgotten, by the hand of one whose brain had gradually but surely lost its retention of ideas. In charity let us pass over this unpleasant fiasco, and once more yield our allegiance to the parent stem and assist Mr. Fowke in smoothing over those past difficulties which happily are not likely to recur again. Of the thirteen members of our Society who have resigned membership, I very much regret to state that most of them were country members. We also must remember that of recent numerous arrivals of members of the profession in this colony, the greater number of them are absorbed by country districts. It is suggestive of critical observation that no new members have joined us during the past year. This leads up to the consideration of the question: as to what advantages do country practitioners derive by joining this Association, and the fact has forced itself upon me that they derive no advantage whatever by joining our ranks. I would therefore suggest it, as a matter of consideration for the incoming Council, to so modify the by-laws or regulations of the Association with the view of offering some inducement and making it the interest of country practitioners to join our ranks and remain with us, and I venture to throw out such hints that could be taken up by the Council, and ultimately, after due notice, submitted to a general meeting of the Branch:—1st. The formation of a library of such expensive and standard works or books of reference that could be utilised by country members when they visit the city. 2nd. The acquirement of an instrument cabinet to contain such expensive and rarely required instruments that a general practitioner may occasionally require, yet too expensive for him to acquire, having but rare opportunities of using them. These instruments—under certain restrictions, and upon payment of a small cost to cover cleaning and allow for carriage, packing, tear and wear—to be lent out to such members that may require them. 3rd. The establishment of an Inquiry Bureau, where country practitioners could, upon payment of a small fee, obtain information concerning professional subjects, obtain analyses of various products, pathological reports upon morbid specimens and such other matters, including the advice and assistance of specialists

in reviewing reported cases of rare and unusual professional interest.

In casting about for some subject upon which to address you to-night, it has forced itself upon me that the subject of public health and State medicine would not be inopportune, considering the present sanitary condition of this colony. I admit that I have been kindly and considerately cautioned to avoid such a threadbare subject, but it is my opinion that all the threads and tissues of this subject have not yet been sufficiently bared and exposed. In addressing a skilled audience, such as I have before me to-night, I am quite conscious that I can say nothing new to you upon this science. I have some hope, however, that I may so frame my remarks so as to suggest matters of thought to the outside public and non-professional people who have fully as great, if not a greater, interest in this subject than the medical profession, and who may possibly in some indirect way learn the substance of my remarks. I shall therefore treat it from two or more points of view, principally dwelling upon the political and the professional, or medical, and endeavour to indicate the part to be taken by each in this important reform. In the home country sanitary progress has made rapid strides within the last thirty years, and various enactments and laws have been passed, from time to time, of such a nature as to exhibit the keen interest which those in charge of the political helm have taken, concerning certain measures which they have deemed it their imperative duty to convert into laws. It has often occurred to me to inquire how it is that in this colony, where our legislators have shown great acumen in improving upon and converting to our local use so many good and useful statutes of the old country, what tardiness they exhibit in following the beaten track regarding the all-absorbing subject of public health. It is true that in this colony we have some attempt at legislation, such as the various Acts regulating quarantine, the slaughtering of cattle, the licensing of slaughter-houses, the powers and duties of the Commissioners of Sydney, the better drainage of lands, the prevention of nuisances in Sydney and other municipalities, the prevention of the adulteration of food and drink, regulating the sale and use of poisons, and, last of all, the Dairies Supervision Act of 1886. These Acts, no doubt, very effectual for the purposes for which they have been intended, form but a small item in striking at the roots of the various evils which contribute towards the sacrifice of human lives by preventable diseases. One Government of this colony tacitly acknowledged the liability of the State to follow the example of the home country by introducing an admirable Public Health Bill. It is in the hope of securing the co-operation of the profession towards influencing public opinion in favour of this very desirable measure, which, while being constructed upon the lines of the Public Health Act of 1875, yet in its construction advantage has been taken of the experience of the mother country and those colonies which anticipated New South Wales in this beneficent form of legislation. It is to be hoped that before long another and more successful effort will be made to make some such bill a legal enactment for this colony.

And now as to the professional or medical aspect of public health and sanitation. While Government is considering and Parliament discussing the propriety of introducing a suitable measure for the protection of lives against preventable disease, the individual members of the profession may prove a great power in educating and training public opinion on this subject, and it is much to be regretted that the majority of our profession deem it etiquette to shrink from boldly stating their opinions and convictions upon the public platform and in the

public lecture-room. As an educated body, it is to be regretted that we are so reticent in such matters that it is the daily business of our life to practise, and which, really we should be most competent to teach. As to the etiquette of publicly advocating sanitary reform, Dr. Styrap, the well-known author of the most reliable work on medical etiquette—and by whose writings we know to be one who would jealously guard the dignity of the profession against any breach of professional etiquette, says emphatically:—"It is a noble, unselfish task to promote health and obviate disease by the judicious application of hygienic science, and by so prolonging life to increase the productive industry, and thus without assuming the function of moral and religious teaching, to advance the civilization of the people." And further on, he thus discusses the duties of medical practitioners to the public:—"That it is the duty of the faculty to be ready to advise the public on subjects specially appertaining to their profession, such as public hygiene, legal medicine, and medical police," as well as "their province to enlighten them with regard to drainage, water supply, ventilation, and sanitation generally, and in respect to measures for the prevention and mitigation of epidemic and contagious diseases." A duty that we should never neglect is, to continually advocate and carry into practice the proper vaccination of the members of families whom we attend professionally. Thanks to an energetic head to our Health Board, several threatened dangers from a visitation of small-pox have been averted, and on one or two occasions, when it got footing within our city, it was fortunately stamped out; but there is yet a possibility that a day may come when such a happy issue from this dread visitor may not happen. Amidst the alarm and panic that then would arise, it would be impossible to properly vaccinate a fractional part of those who would then require it. It is clearly, then, our duty as members of the medical profession, collectively and individually, to use our professional and personal influence in advocating publicly, privately, and by every means in our power, sanitary reform in the homes of those whom it is our daily duty to visit. One great factor in working up public and private interest in sanitary measures will be the cordial assistance that the profession will give in co-operating with the authorities as to the immediate notification of cases of infectious diseases. Much prejudice has been felt by some members of the profession against this measure, they deeming it a breach of professional confidence to give such information. As for my own part, after a calm and exhaustive consideration of all the arguments and discussions on this matter, I have come to the conclusion that the only way to arrive at statistics of preventable disease—which must be first considered before we can study the causes of all such—will be the voluntary and hearty co-operation of the profession in carrying out this movement. Ten years ago, when I was Editor of the *Australian Practitioner*, I experienced the cordiality with which the profession of this colony responded to any movement tending to ameliorate the insanitary condition of this colony by the numerous responses that I received in reply to a series of printed questions concerning the prevalence, cause, and proposed abatement of preventable diseases in various localities. I trust the members of this Branch will not wait for Parliamentary enactment, but will without delay institute a quarterly inquiry, by printed papers, as to the prevalence of preventable diseases in this colony. By so doing, and with the assistance of our metropolitan and country colleagues, we shall be rapidly pushing on towards sanitary legislation of the right sort.

The Hon. Treasurer (G. T. Hankins, Esq.,) read the

Financial Statement and Balance Sheet, shewing a balance of £207 1s. 6d. to the credit of the Branch.

Dr. SCOT SKIRVING proposed and Dr. Quaife seconded "That the Balance Sheet, as read, be adopted." Carried.

Dr. QUAIFE proposed "That a hearty vote of thanks be accorded to the Hon. Treasurer for the trouble he had taken with regard to the financial matters of the Branch." Carried.

Dr. ELLIS seconded the proposition, and said that as one of the Auditors he could testify to the enormous amount of work that Mr. Hankins must have had in getting matters straight. He (Dr. Ellis) would personally thank Mr. Hankins for the way the accounts were placed before the Auditors, thus making their labours exceedingly light.

Dr. SHEWEN proposed "That the thanks of the members are due to Dr. Knaggs for his address." Seconded by Dr. W. Chisholm, and carried.

The Hon. Dr. CREED proposed a vote of thanks to the Auditors, Drs. Ellis and Crago. Carried.

The following gentlemen were elected members of the Council for the ensuing year:—Drs. Knaggs, Chambers, Skirving, Hankins, Quaife, O'Reilly, Fiaschi, Creed, McCormick, and MacLaurin.

The election of office bearers then took place as follows:—The Hon. J. M. Creed, M.L.C., was elected President; Dr. Chambers, Vice-President; Dr. Scot Skirving, Hon. Secretary; G. T. Hankins, Esq., Hon. Treasurer; Drs. Ellis and Crago, Auditors.

Dr. ELLIS proposed a vote of thanks to the retiring officers. Seconded by Dr. Crago, and carried.

Dr. Knaggs then retired from the chair, which was taken by newly-elected President (Dr. Creed), who thanked the members for the honor they had done him by his election.

The Hon. Secretary (Dr. Skirving) announced that he had received the following notices of motion:—

Dr. CLUBBE to move—1st—"That this Association is of opinion that the present system of payment of Medical Officers by the various Friendly Societies is very unsatisfactory." 2nd—"That a Committee be formed to inquire into the subject and to formulate some scheme of reform."

Dr. KNAGGS to move "That this Branch take measures to inaugurate the quarterly registration of preventable diseases in this Colony."

Dr. HAYNES LOVELL to move "That at future meetings the press shall be requested not to give particulars of any professional papers except by the invitation of the President."

Dr. QUAIFE to move "That the resolutions passed by the Branch on 6th August, 1886, relative to subscriptions and B. M. Journal, be now rescinded."

A CORRECTION.

In our last issue we recorded the death of Dr. C. H. Maher who, however, we are pleased to inform our readers, is still in the flesh, and will, we hope, continue to be so for many years to come. The gentleman who died from typhoid fever was his younger brother, G. H. Maher, LL.B., the similarity of initials causing the mistake, which we regret should have occurred. Our informant was apparently so well informed that we accepted the account he gave without misgivings as to the accuracy of his information.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which, if found on perusal to be consonant with the policy of the paper, will be inserted in an early number. All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, MARCH 15, 1887.

EDITORIALS.

THE OUTBREAK OF TYPHOID IN BURWOOD (NEAR SYDNEY) AND NEIGHBOURHOOD.

THE first information received by the Board of Health as to this outbreak was by a communication from a resident in Burwood, who, on February 14, reported that he had fever in his family, and that he knew of a few cases in other households, all of which were supplied by the same milkman. On February 15 a letter was received from a medical man at Burwood saying, that of eleven cases of typhoid under his care, nine took milk from this dairy. On the 16th another letter was received from another practitioner in the same place saying that he had nine cases of fever under his care, all supplied with milk from the same place. Prompt action was taken by the Health Authorities, the secretary communicating, on February 14, with the Mayor of the district in which the dairy was situated. This official, as the local authority under the Dairies Supervision Act, took prompt action by obtaining samples of the milk, and of water from the well supplying the dairy, and by examining the premises. On February 17 the registration of the dairy was cancelled, and it was proposed to fill up the well, which analysis showed to yield exceedingly foul water. The Board of Health approved of this action, and it was accordingly done under the supervision of the police.

It may be remarked that though the outbreak amongst the customers of this dairy took place in the municipality of Burwood, the dairy was situated in and was registered by that of Concord. It appeared, on investigation, that this dairy ought never to have been registered on account of the water supply, and, in fact, the local authorities of Concord hesitated to do so; but the dairyman had already been registered in Burwood as a vendor, and this fact turned the scale in his favour when his application for registration was before the Concord authorities.

This incident shows that all local authorities should make it a rule to register no man as a vendor in their own district until he has produced to them his certificate of registration as a dairy-keeper from the district in which his dairy is situated, supposing that it is in another district from that in which he is applying.

It is but fair to the Concord local authorities to state that they assert that there have been no cases of typhoid amongst this man's customers in the Concord district, but only in that of Burwood and Strathfield, and they claim that the fever has arisen from local causes and not through the milk supply. Whether this assertion of the Concord people is founded on fact we cannot, from the information at our disposal, at present say. We think the evidence is overwhelming in favour of the theory that the infection was distributed through the milk supplied by this dairy. This one case alone proves the advantage of the recent legislation, for without the Dairies Act the Health Authorities would have been powerless to close the dairy (which was done within three days of the first information being received), and the dairyman, if an unscrupulous man, might have persisted in carrying on his terrible business, even could have brought an action for damages against any doctor who warned his patients and friends against his milk, and might have continued to spread death and disease in spite of every one.

The Act is not perfect, but it is a great step in the right direction, and when time and experience have brought about something like uniformity in its administration by the various municipal bodies which work under it, its defects will not be found to be very great or incapable of remedy.

The outbreak of enteric fever at Leichhardt, and one at North Shore, just before Christmas, were clearly traced by Dr. Ashburton Thompson to the milk supply. Impure milk is a much more important and general factor in the spread of typhoid than is generally supposed, and it is much to be wished that it should become the custom in every household to boil all milk before using it.

MEDICAL DEGREES FOR LADIES.

At a meeting of the Council of the University of Melbourne, on February 21, it was decided by a large majority to admit ladies as students of medicine. We are pleased to say there were only three dissentients to this course, but must express our regret and surprise to find that these gentlemen were Drs. Brownless and Cutts with Mr. Ellery.

We are of opinion that women should be allowed to follow any calling for which they are fitted, and no one but a narrow-minded individual would deny that medicine is one of them. They should be granted every facility for being thoroughly trained for the calling they take up, and, when they enter into competition with men, should receive no advantage and lie under no disadvantage on account of their sex.

We cannot too highly congratulate the Melbourne University on the marked advance in the liberality of ideas possessed by its present governing body when compared with the action taken by that holding sway in 1871, when the sister of the Editor of the *A.M.G.* was refused leave to matriculate in arts, she having been one of the first two ladies to pass the matriculation examination. Her demand for matriculation was met by a simple refusal, any explanation of the reasons for such refusal, other than the fact that the University did not choose to grant degrees to ladies, being declined to be given.

In Sydney there are already lady medical students attending lectures and going through the usual medical course. Steps are also being taken to establish a college for women to be affiliated with that University.

ALLEGED MISTAKEN DIAGNOSIS.

In the Melbourne *Argus* of February 10th appeared a paragraph which shows how little consideration is shown to the profession should opportunity occur giving the lay press an excuse for hostile criticism. It seems a woman named Best was seen by a medical man, who, having examined her, found such symptoms as induced him to believe she was suffering from enteric fever, the diagnosis being confirmed by the medical officers of the Melbourne Hospital, where she was subsequently admitted. There she died, and on a *post-mortem* being made it became manifest she had been suffering from septicæmia, the result of an operation to procure abortion. We think it not improbable that there may have been typhoid infection co-existent with the septicæmia, but whether this was the case or not, we think the

mistake, if a mistake was made, very excusable, for an essential factor in every diagnosis is the information given by the patient as to how the disease first showed itself, and a physician is heavily handicapped in forming a correct decision when he is wilfully deceived by the concealment of important facts or by lies told him by the patient.

THE WOMEN'S HOSPITAL IN MELBOURNE AND DR. BALLS-HEADLEY.

We feel compelled to express our regret at the action taken by the Committee of this Institution when dealing with the application of Dr. Balls-Headley for leave of absence in order to visit Europe.

When a medical man has given ten years' gratuitous professional service of a highly valuable kind, it certainly appears to us that the managing body of the Hospital exhibit but little sense of the gratitude which he has a right to expect when they refuse a few months' leave on urgent occasion. We fear this is but an example of the general absence of gratitude which is common to the lay mind when the gratuitous services of the profession are considered.

Dr. Balls-Headley has, we hear, expressed his intention of postponing his trip home in consequence, and we can only condole with him in the fact that he is connected with a governing body who have so little consciousness of decent right.

We are pleased to add that the action of the Committee will not go unchallenged, for a most influential and numerously signed requisition has been sent to them demanding that a special meeting of the subscribers be called to take into consideration their conduct in refusing leave of absence to Dr. Balls-Headley. Protests were also sent to the Committee by the Medical Society of Victoria and by the other members of the honorary medical staff.

AN UNUSUALLY INTELLIGENT CORONER'S JURY.

At an inquest touching the death of an infant, held before the Coroner for the City of Sydney on February 17, the following verdict was given by the jury:—"That the deceased died from starvation, and that the father was responsible for not having attended to it." They added a rider to the effect "that they considered the conduct of Mr. Cowan was reprehensible in having 'Doctor' painted on his house and selling medicines which he admitted would neither do good nor harm."

We do not call special attention to this case because it is at all remarkable in New South Wales, for we believe that similar cases of pretended treatment by quacks, with resulting death, occur every week, and did we mention every similar case that came under our notice, we should half fill every issue of our journal.

The circumstance worthy of remark in the case is the abnormal intelligence shown by the jury in their verdict.

THE INTERCOLONIAL MEDICAL CONGRESS.

We understand that the Governors of N. S. Wales, Victoria, Queensland and South Australia have all in cordial terms accepted positions as patrons of the Congress; the Governor of Queensland especially expresses his approval of a movement which, he is sure, will confer much benefit on all the colonies. The Presidents of the Medical Association of New Zealand (Dr. Hocken), the Auckland Branch of the Medical Association of New Zealand (Dr. Dawson), the Wellington Medical Association (Dr. Alex. Johnston) have accepted positions as Vice-Presidents of the Congress. Time has not been given to receive answers from all the societies which have been asked to assist. The Reception Committee is taking active steps to secure concessions from the Railway Department for reduced fares on the various lines for members of the Congress. The S.A. Government has promised to reduce their fares one-half, and, on the representation of the Editor of this journal, the Commissioner for Railways in New South Wales has promised to make a similar concession, provided the authorities in Victoria will not be less liberal. The Executive Committee propose shortly to issue a circular announcing the final arrangements of the Congress. Their work will be much facilitated if gentlemen proposing to contribute papers would intimate at an early date the subjects they intend to treat. Although the time up to which intimation of papers may be sent is June 30th, it is very desirable that all members intending to send in papers should do so at their earliest convenience. We also learn that Professor Watson has written from Calcutta, to the effect that some visitors may be expected from India; in fact, everything seems to contribute to make the Congress a thorough success.

TYPHOID FROM A SINGLE DOSE.

WITH enteric fever so great a scourge in Australia we think the accompanying note, from the *British Medical Journal* of November 27, 1886, cannot fail to be of public interest, and in view of the fact that it may be a means of impressing on the public the extreme danger of imbibing even small quantities of contaminated water, we republish it:—

" M. Dujardin-Beaumetz has forwarded to the Paris Academy of Sciences a communication on the Pierrefonds typhoid cases last summer. M. Fernet, who occupies a high post at the Ministry of Public Instruction, his wife and family, hired a house at Pierrefonds, a fashionable resort near Compiègne, contiguous to two others. After they had rented it for the season they were told to beware of the water in the well. On this account they drank exclusively mineral water until the last day, when the stock was out, and the servants were too busy preparing to return to Paris to go and fetch some bottles from the chemist. Madame Fernet said 'for once surely there can be no harm in drinking the well-water.' They drank it. Six out of the nine persons have since died, including one of the servants. The cook, two of the four children, and Madame Fernet had had typhoid fever before, and though attacked by it again after their return from Pierrefonds, have got through the illness. The well has been examined and is reported to contain the bacilli which are believed to be associated with typhoid fever. This is a common danger to which visitors to so-called health resorts, both on the Continent and at home, are frequently subjected. The facility with which well-water is infected is hidden from the population by the impunity with which filthy well-water may often be drunk by resident families who have become acclimatised, especially when that water is for the moment infected only by non-poisonous faecal matter; and this fancied immunity often leads to habits of carelessness for which, not themselves only, but their visitors have to suffer."

LETTERS TO THE EDITOR.

CLUB PRACTICE, &c.

(*To the Editor of the A. M. Gazette.*)

SIR,—It was with great pleasure I read your article in February's number, as I have ever felt strongly on this subject, and, from a lengthened experience in the colony, regret to say your views are only too true. Surely the time has arrived when the profession should take steps to remedy the several injustices we have to submit to in this and other matters.

The lack of *esprit de corps*, so predominant in too many of our brethren, enable the public to take advantages and treat us with a courtesy unheard of in other professions.

With reference to club practice, I would here narrate a fact that happened some six years ago,

authenticated by a well-known member of the profession residing in Sydney. A tender was made for a certain club in Sydney actually offering to undertake the medical duties at 1s. per head less than anyone else tendering. Further comment is unnecessary.

It has ever been my endeavour to uphold the dignity of the profession with clubs by refusing to attend those members who I deemed were taking undue advantage of a society, and by adhering to the following rates :—80s. per member per annum, visits 3s. per mile, midwifery £3 3s. and £4 4s., which charges are but legitimate where wages rule so high.

Insurance Work in the Country.—This subject was so graphically described by your correspondent in your January issue, that it is unnecessary for me to do more than refer to it, but I may add, I have, in two or three instances of late, known insurance agents having an unqualified man with them as their medical referee. Healthy for the Society!!!

Coroners' Inquests.—Is it not almost incredible that a professional man should be compelled by law to attend and give evidence at such inadequate remuneration. Say the inquiry is 20 miles from your home, this means a fee of ten shillings for travelling 40 miles, a gross injustice.

In conclusion, may I ask your valuable aid, urging the leading members of the profession in Sydney to take the initiative to form an association to defend ourselves in these and other matters requiring reformation. I shall be glad to hand you my cheque for £5 5s. as a first instalment towards such an end.

Yours obediently,
W. G. T.

March 1, 1887.

SIR,

Thanks for your able article *re* Clubs, but it would take a Carlyle to arouse our lost-to-shame citizens to a sense of honor. They, with the innocence of Ah! sin, and the cupidity of Shylock, think medical men fit subjects to work their spare duplicity upon. I will give two instances of many I know: one, the manager of a very wealthy city firm, with a salary of £1,000 a year, besides a private income, not only has his club-doctor, but made him understand that his position greatly depended upon his pleasure. His position! What a degradation to a "noble" profession. The other is foreman over some 900 men, with his £600 a year, yet has the club-doctor in constant attendance. To what a depth of humiliation has the profession—that produced a Jenner, an Abernethy, the Hunters—sunk? It is a wonder they do not rise up and smite us for permitting such rascality—Enough! it is our own fault—so let us suffer.

M.R.C.S.

TRACHEOTOMY IN CROUP AND DIPHTHERIA.

(*To the Editor of the A. M. Gazette.*)

SIR,—In compliance with a request made through you by a number of your readers that I should "furnish them with a more detailed account of the after-treatment—medicinal and diet"—of the tracheotomies performed by me (notes of which have lately appeared in your journal), I crave a small portion of your valuable space to enable me to supply the desired information.

In the published account I have already stated that eucalyptus oil was freely used about the room in all the cases, and that a piece of lint smeared with eucalyptus vaseline (1 in 8) was daily applied between the shield of the tube and the wound. To these means, combined with the keeping of the tube clear, I attach much more value than to any medicinal treatment.

As no two of the cases received precisely the same medicinal treatment I must specify each separately; but this very fact will tend to show that it (the medicinal treatment) was not a very important factor in the success of the cases.

In case No. 1, a mixture containing ammon. carb., liq. ammon. acet., vin. ipecac., et dec. cinchona was given for a week as there was slight bronchitis and a temperature exceeding 102° F. for three or four nights; afterwards a mixture containing tinct. ferri perchlor. was given. Neither brushing the fauces nor steaming the orifice of the tube was adopted in this case.

In No. 2, vomiting being the chief symptom, a bismuth mixture was given with lime water and milk.

In No. 3 a mixture containing m. v. Ol. eucalypti in each dose, combined with small doses of paregoric and squill, was given for a week, and after that a mixture of pot. chlor., c. tinct. ferri perchlor. was substituted. The fauces were brushed daily for the first week with liq. sodii chlor. et glycerin p. seq.

In No. 4 no medicine was given for first two days, then a mixture containing gr. v. sodii sulphocarb. in each dose was given three times a day for three or four days, and afterwards a mixture of pot. chlor. c. tinct. ferri perchlor. was given for a time, which was finally replaced by Parrish's syrup. The fauces, although the seat of extensive deposit, were not brushed on account of the persistent struggling of the patient. The orifice of tube was frequently sprayed with steam impregnated with Ol. eucalypti.

In No. 5, no internal medicine during first two days, then the following mixture was given for four days :—
B. Liq. hydrarg. perchlor., 3iii. Potassii iodidi. gr. x., Ferri et ammon. cit. gr. xx., Glycerini 3ss. Aquam ad 3ii. m. ft. mist. 3i ex aquâ ter in die sumenda, and after that a mixture of pot. chlor. c. tinct. ferri perchlor. was substituted. The fauces were brushed twice a day with a solution of permanganate of potash, and the orifice of tube sprayed with eucalyptus steam.

Diet: milk, beef-tea or chicken broth, and eggs were the chief articles of food in all the cases for the first few days. Some lime-water was added to the milk in most of the cases, and where it appeared necessary a little brandy or wine was allowed—mostly given with egg and milk. Jellies, custards, sponge cakes, bananas or ripe pears were allowed where the children craved for them. In all the cases nourishment was almost greedily taken for the first 24 hours, after which, for a day or two, there was a disinclination to take much food. In no case did I find it necessary to feed through a catheter, or "per rectum," as even in the cases where fluids came out through the tube it only caused a

momentary cough, and light solids were swallowed without any difficulty. Towards the end of the first week, a little fish, chicken, or light-boiled egg, with bread and butter, was allowed.

In all cases the patients were kept in bed until after the tubes were removed.

WM. H. CRAGO.

82 William Street,
Sydney, March 2, 1887.

PROLEGOMENA ON DRUMINE.

(To the Editor of the A.M. Gazette.)

Sir,—As sinister motives and preconceived ideas are apt to be ascribed to a man who claims to be the author of a discovery, it is, I think, right that the writer should mention some of the incidents connected with his discovery of Drumine. They are as follows:—A farmer complained that the loss of stock, occasioned by the animals eating a poisonous herb, had almost ruined him financially. I asked if he knew of any antidote, and on receiving a negative reply, I resolved to make experiments, with the intention of finding one. On finding some peculiar paralysing properties, I wrote to Dr. Schomburgk and received the following reply:—

Botanic Gardens, Adelaide,
29th June, 1886.

Dear Sir,—The plant you sent me is one of the most poisonous of S.A. It is a Spuretic (*Euphorbia Drummondii*). A large number of sheep and cattle are annually killed by eating it. It comes under inflammatory poisons, and the poisonous principle resides chiefly in its milky secretion, and is more powerful in proportion as that secretion is abundant. To the inflammatory poisons belong also oleander, cerbera, castor oil tree, lumach, laurel, daphne aroids, also nettles and others. The noxious effects of these plants are felt in the mouth or on the skin creating a strong irritation, a violent burning inflammation and blisters, followed by destruction of organic substance. I regret, through indisposition, not having answered your letter before.

Yours faithfully,
R. SCHOMBURGK,
Per H.S.,
Director.

Dr. John Reid,
Port Germein.

This letter, as might well be imagined, induced me to verify my previous experiments and to make full inquiries already found in the *A.M.G.*

The experiments of Mr. Stanley in N.S.W. bear out my conclusions—for I think I may safely say hoven is due to want of digestive power and consequent increase of gases in the gut, with development of low organisms. There is a want of reaction to the demand of food to be acted on so to speak, but as this has already been entered into I need not recapitulate. The want of general poisonous effects is well shown in its use for large abraded surfaces of burns, &c.

Yours, &c.,
JOHN REID, M.A., M.D.

11, Spring Street, Melbourne.

ANTICS OF CORONERS.

(To the Editor of the A.M. Gazette.)

SIR,—In your issue of last month appears an article under the heading of "Antics of Coroners," in which my name is mentioned in connection with an inquest at Bathurst on the body of a Mrs. Lowe, who died suddenly. I trust, therefore, you will accord me space for reply.

Upon learning, shortly after the "inquiry," that Dr. Machattie had been called in by the family of the deceased to see the body, and afterwards directed by the police to attend the inquest (without the knowledge of the coroner), I called upon Dr. Machattie at the earliest opportunity with some explanation, and, considering he was suffering from a *mistake*, and not as a right, I offered to remit the fee to him, which, however, he declined to accept.

With regard to the clause of the "Medical Witnesses' Act" on the matter, after perusal of the same, and from the opinion of others, I do not agree with you in its *interpretation* and meaning, as it is, I believe, intended to avoid extra expense to the Crown, which did not occur in this case, and, therefore, *legally* the coroner had as much right to summon me to the case as to summon any other qualified practitioner there.

I may observe that I have been a temporary resident of Bathurst, on many occasions, during the last *seven years*, and have never been the recipient of any "fee" from the Department of Justice, with one exception only—a few years back, for a case of lunacy—which was a matter of convenience to the police, as the opinion of a second medical practitioner was required, which was not at that particular time available without mine.

I am, yours, &c.,
W. P. LEE, M.R.C.S., &c.

Parramatta, 5th March, 1887.

[The Medical Witnesses' Act specifically says "some legally qualified medical practitioner in *actual practice* who shall reside near to the place where such inquest is holden." We have yet to learn that Dr. Lee was practising at the time in Bathurst, and we prefer our own interpretation of the Act to that of other unknown persons.—ED. *A.M.G.*]

TRAVELLING IMPOSTORS.

(To the Editor of the A.M.G.)

SIR,—It came to my knowledge about a month ago, through a patient from a Northern township, whom I was treating for deafness, that a person had passed through her district representing himself as "Dr. Brady, from Sydney," and professing to treat ear diseases. As such a person might impose on my medical brethren in the country, I should be glad if you would make known through the *Gazette*, that I do not travel about the country in my professional capacity.

Truly yours,
A. J. BRADY.

3 Lyons' Terrace, Sydney, March 10, 1887.

REVIEW.

MASSAGE AS A MODE OF TREATMENT.

BY WILLIAM MURRELL, M.D., F.R.C.P.
(SECOND EDITION.) LONDON: H. K. LEWIS, 1887.

DR. MURRELL has written a most interesting, readable, and useful little work. If it serve to dispel some of the really delicious ignorance regarding massage as a method of treatment existing in too many professional minds, and save it from degenerating into monstrous quackery, it will not have been penned in vain.

Massage is as old as the remedial art itself. In chap. 2 the author tells us that it was known both to the Greeks and Romans and to the Chinese 3000 b.c. Hippocrates, Celsus, Galen, and others give much useful information regarding the early history of massage. Massage and the ordinary shampooing of the Turkish bath are by no means synonymous. "There is as much difference between massage and shampooing as there is between playing a difficult piece of music and striking the keys of the pianoforte at random."

The method of performing massage is clearly laid down. According to Dr. Murrell the masseur or masseuse must be both educated and accomplished. They "must have such a knowledge of surface and visceral anatomy and of physiology as will enable them to carry out the instructions of the physician intelligently"—"fair education and a certain form of refinement"—"a knowledge of the leading facts of anatomy," etc.

We are on the very tiptoe of excitement for the arrival of such a class of men and women. What a lofty position they would occupy in a colony like N. S. Wales, where more than 180 practitioners of medicine and surgery have never been to college at all! It is beyond the highest flight of imagination. But we protest Dr. Murrell expects too much, unless, like several continental specialists, the doctors do the massage themselves.

The séance is a point of great importance, and is well and graphically described. The use of massage in paralysis, infantile and hysterical paralysis, locomotor ataxy, rheumatism, spinal irritation, and various neurotic affections is discussed.

It may be of interest to our fashionable physicians to know that "a physician who recently called on me from Sydney, told me that it (massage) was of great service for women who had been long in Australia, and who were getting stout."

There is abundance of proof that massage is an excellent therapeutic agent. Though we object to the quasi-scientific pre-eminence given to it by the author, we rejoice to see it rescued from the hands of unscrupulous, ignorant quacks, and cordially recommend the perusal of this work by all those who wish to see an ancient and highly useful adjunct to our practice restored to an honorable place.

Dr. Murrell is to be congratulated on the elegant and scholarly style of his diction, and the interest infused into an otherwise ordinary and colourless topic.

OBITUARY.

JOHN BLAIR, M.D., F.R.C.S. EDIN.

It is our painful duty to record the death of Dr. John Blair, one of the oldest and best known medical men in Melbourne, who died at his residence, 101 Collins-street East, after a protracted illness, on March 9, at the age of 52 years. The deceased gentleman was a native of Linlithgowshire, Scotland; he studied in Glasgow and Edinburgh, and in 1857 he became a Licentiate, and in 1874 a Fellow of the R.C.S. Edin.; he was also an M.D. of both the Universities of Melbourne and Sydney. He came to Victoria in 1859, and practised for some time at Northcote, but, after a while removed to Melbourne, where, with the exception of a visit to the old country a few years ago, he has since resided. Soon after his arrival there he became connected with the Medical Society of Victoria, of which he was honorary secretary for 10 years, when he was elected its president. In 1867, when the movement having for its object the foundation of a Prince Alfred Memorial was started, a project which eventually resolved itself into the Alfred Hospital, Dr. Blair took a prominent part in promoting its accomplishment, and, on the completion of this charity in 1870, he was elected one of the honorary surgeons, an appointment he continued to hold up to the time of his death. In this institution he has always taken great interest, and has published several pamphlets bearing upon hospital management. Some years ago he was appointed a member of the Medical Board of Victoria. Dr. Blair was also a connoisseur in pictures, and at one time painted a little himself. He leaves a widow, but no children. The funeral took place on March 10, and was attended by a very large number of representative citizens.

THE MONTH.

NEW SOUTH WALES.

We are requested by the Health Authorities to state that they are in receipt of a large supply of fresh human vaccine lymph from England, a small quantity of which will be forwarded to each legally qualified medical practitioner upon application to the Secretary to the Board of Health, 127 Macquarie Street, Sydney.

FULLY fifty severe cases of typhoid have lately been reported from Burwood and Strathfield, two suburbs 7 miles from Sydney, while there are a number of people suffering from slight attacks. Nearly all the cases have arisen from the use of milk contaminated by the water used in connection with a dairy at Concord. The water, on analysis, was found to be one of the worst samples of water ever tested, and quite unfit for consumption by human beings, consequently the dairy has been closed and the waterhole filled up by order of the Board of Health under the new Dairies Supervision Act, which came into force on January 1st, of this year.

AT the annual meeting of the subscribers to the Hospital for Sick Children, Glebe Point, Sydney, held on February 14, Dr. R. Scot Skirving presented the medical report, which showed that during the past year 315 patients had been treated within the institution, of whom only 18 had died—a satisfactorily small number considering the grave character of many of the cases. The operations performed numbered 45, many of them having been of a severe character, such as amputations and operations on joints and the respiratory passages. It was with satisfaction that the medical staff expressed their thanks for the energetic and loyal help they had received from the nursing staff in the treatment of the little patients under their care. The report again directed attention to the desirability of obtaining the services of a house surgeon, and of a new situation for the hospital, with improved sanitary arrangements.

A SCHEME is on foot for the formation of a college for women in connection with the University of Sydney.

A MAN, named W. C. Wagstaffe, aged 33, died at the Sydney Hospital on Saturday, March 5th, whilst under the influence of chloroform, administered by Drs. Clay and Fisher, two of the resident medical officers, who, at a subsequent inquest on the body, were exonerated from all blame.

SIR HENRY PARKES laid the foundation stone of a new hospital at Cootamundra, on March 3.

THE new wing of St. Vincent's Hospital, Sydney, now in course of erection, will give accommodation to 80 additional patients. It will cost £9000.

DR. A. BARBER, formerly of Narrandera, has returned to the colony from his trip to England.

DR. W. R. CORTIS, M.P., was banqueted at Bathurst on March 1; the banquet was well attended by all the leading citizens, about 80 being present, the chair being occupied by the Mayor, Dr. Machattie.

DR. JAMES FERGUSSON, M.D. Glas., 1882, died at Moruya on February 25. The deceased gentleman was for many years medical officer to the hospital at Alexandra, Victoria.

We learn that Dr. Louis FitzPatrick, of Queanbeyan, has been elected a member of the Royal Irish Academy, Dublin.

DR. E. A. HAYNES, Medical Officer at the Quarantine Station, North Head, Port Jackson, during the late epidemic of smallpox on board the German Mail S.S.

"Preussen," has settled at Gunnedah, in a pastoral and agricultural district, 265 miles N. of Sydney; Dr. Haynes has been appointed Surgeon to the local Hospital.

DR. G. L. L. LAWSON, late of Auckland, has settled at Balranald, on the Murrumbidgee River, in a fine pastoral district, 554 miles S.W. of Sydney.

DR. W. McMURRAY, of Hyde Park, Sydney, has recommenced practice at Walgett, in a pastoral district, 450 miles N.W. of Sydney.

DR. A. J. MACQUEEN, of Hyde Park, Sydney, formerly of Forbes, has succeeded to the practice of Dr. T. B. Waller, at Narrabri, in a pastoral and agricultural district, 321 N.W. of Sydney.

DR. P. E. MUSKETT has removed from 183 William-street, Woolloomooloo, to Sherwin Terrace, 135 Elizabeth-street, Hyde Park, Sydney.

DR. G. J. L. O'NEILL has commenced practice at Elizabeth-street South, Sydney.

LEONARD SELWAY, L.S.A. Lond., 1884, formerly at Jerilderie, died at Narrandera on March 3, at the early age of 27.

DR. J. C. SHAND, a recent arrival, has commenced practice at Penrith.

DR. W. H. TOMLINS, late of Wallsend, has settled at Wardell, on the Richmond River, in a sugar and timber-growing district, 353 miles N. of Sydney.

DR. W. A. WOOD has resigned his appointment of Resident Medical Officer at the Prince Alfred Hospital, Sydney.

QUEENSLAND.

DR. S. H. EDGELOW has commenced practice at Rockhampton, where he has been appointed Medical Officer to the local Benefit Societies.

DR. J. R. JOSEPH, late Resident Surgeon at the Maryborough Hospital for Pacific Islanders, has recommenced practice at South Brisbane.

SOUTH AUSTRALIA.

THE seventeenth annual report of the board of management of the Adelaide Hospital, shows that the number of cases admitted to the institution during 1886 was 1878 against 2024 in 1885, whilst the number of deaths of in-patients was 164 against 153 in 1885. The annual cost of each in-patient was £51 1s. 10d., against £53 4s. 8d. during the previous year. The number of attendances of out-patients treated was 10,320, against 7,445 in 1885, and the total annual expenditure amounted to £9,679 8s. 6d. The number of cases of enteric fever treated during 1886 was 87 cases and 8 deaths, showing a considerable decrease on the preceding year, when 165 cases were treated, with 16 deaths.

GREAT indignation is felt at Hergott Springs, and among the men working on the railway, against Dr. Baker. At an inquest on the body of a man named Wattlin, who died from exhaustion, the jury censured Dr. Baker for neglect and heartless conduct. The doctor's explanation has not yet been received.

DR. J. W. YEATMAN, of Narracorte, has removed to Saddleworth, in one of the most fertile wheat-growing districts, 68 miles N. of Adelaide.

DR. ARTHUR RICHARDSON, of Teetulpa, has been appointed a Justice of the Peace.

VICTORIA.

THE University Council, on February 21, approved of the principle of ladies being admitted to compete for medical degrees. A resolution to this effect was carried by a large majority, and it was decided to refer the question to the Faculty of Medicine, and to ask that body to recommend the best means by which the principle can be given effect to.

DR. G. A. SYME, formerly Resident Medical Officer at the Melbourne Hospital, has been appointed Demonstrator of Anatomy, also Examiner of Descriptive and Surgical Anatomy at the Melbourne University.

THE Committee of Management of the Alfred Hospital, Melbourne, met on February 11, when nine applications were received for the office of resident medical officer, rendered vacant by the resignation of Dr. Backhouse. By a recent resolution of the committee it was decided that in future, instead of having a senior and junior resident medical officer, there should be two officers of equal standing, one to take charge of the medical, another to superintend the surgical wards. Four candidates applied for the position of physician, and a ballot being taken it was found that Dr. A. S. Joske, late junior resident medical officer, had been elected by a majority of 14 to 2. For the office of surgeon there was a very close poll, resulting in a tie between Dr. Kilpatrick and Dr. John Sutherland. The president gave his casting vote in favour of the latter, who was therefore declared duly elected.

AFTER Mr. T. Prout Webb was appointed to the position of master in lunacy, he caused the most careful inquiries to be instituted as to the ability of relatives and friends of lunatics to contribute towards their maintainance. The vigour with which these investigations were conducted, resulted in the number of paying patients being increased from 319 on December 31, 1884, with total payments of £6,500 on their behalf, to 408 on December 31, 1885, and the income obtained on their behalf to £8,797; while on December 31, 1886, the paying patients numbered 650, and the revenue returns from their relatives amounted to £10,500. This great increase in the number of paying patients has been affected without any addition having been made to the ranks of the inmates of the asylums.

THE number of typhoid cases reported to the Central Board of Health from the 1st January to March 10, has been 836, and 179 of the patients have succumbed to the malady.

THE Central Board of Health proposed to establish a camp hospital for patients suffering from typhoid fever, on a secluded site within the Royal Park. This project, however, had to be abandoned, the reason assigned being the scarcity of water in the locality, though, in reality, the carts loaded with tents and the necessary building material had been refused admission at the Royal Park by order of the trustees. The alternative site in the Alfred Hospital grounds was then accepted, and on February 15, the temporary buildings were placed in position. They comprise four tents supplied by the Defence department, and two portable houses granted by the Railway Commissioners. The use of the Hospital Grounds for the accommodation of typhoid patients was granted to the Central Board of Health on the following conditions:—

"That the Central Board of Health shall provide—

- "1. Tents fully equipped with beds, bedding, furniture, baths, &c.
- "2. Shall erect and remove the same, or any temporary erections, at their own expense, and make good any damage done to the grounds.

"3. Shall take care to have drainage properly laid down, on the same system as now in vogue.

"4. Shall provide, at their own expense, a duly qualified medical officer to take charge of the new patients.

"5. Shall pay to the Alfred Hospital all expenses incurred in maintaining the patients in their tents.

"6. That medical officer and patients are to come under and be amenable to the rules of the Alfred Hospital.

"The Alfred Hospital is to—

"1. Place the patients under their hon. medical staff.

"2. To supply food, medicine, and nursing, and to find board and residence for the extra medical officer."

AN emergency meeting of the honorary medical staff of the Alfred Hospital was held at the hospital on February 14, Dr. W. H. Embling in the chair. The meeting was called in consequence of the present typhoid epidemic necessitating immediate action, and the following resolution was unanimously adopted, and forwarded to the Central Board of Health:—

"That the honorary medical staff of the Alfred Hospital are of opinion that no special appointment of a medical officer need be made in the present emergency, as they are willing and able to perform the extra work."

AT a subsequent meeting of the Committee of Management of the institution, a letter was received from the Central Board of Health, conveying thanks to the hon. medical staff for having forwarded to the Board the above resolution. Several members expressed the opinion that the letter from the staff should first have been submitted to the managers for their approval. Ultimately the following resolution was carried:—

"That the honorary medical staff having taken upon themselves to make a communication to the Central Board of Health, the managers request some explanation as to why such action has been taken without communication with the managers."

HIS Excellency the Governor generously offered the saluting battery reserve in the Government House Domain as a site for a temporary Fever Hospital, but as arrangements had been made for the use of the Alfred Hospital grounds, the Government were unable to accept the offer for the present. Should necessity arise at any future period, they will gladly avail themselves of the Governor's generosity.

A DRIVER for a wholesale milk dealer at Epping, near Melbourne, has been fined £20, with three guineas costs, or one month's imprisonment, for selling milk to which 12 per cent. water had been added.

A SUM of £250 is to be paid to Professor Allen as a doceur for the services rendered by him to the Melbourne University in procuring the transference of the pathological specimens from the Melbourne Hospital to the University.

THE divorce suit Weeding v. Weeding and Dr. Rose, M.P., commenced in the Supreme Court on February 15. The petitioner is Mr. J. H. Weeding, baker. He sued *in forma pauperis* for a divorce from his wife on the grounds of her adultery with Dr. Rose, M.P. for North Melbourne. Weeding claimed £1000 damages. The judge prohibited the evidence being published on the grounds of public morality. The hearing of the case was concluded on February 25, when the jury, after three hours' deliberation, gave a three-fourths verdict in favor of the petitioner on two counts of adultery having been committed by the respondent with Dr. Rose; they also awarded petitioner £100 damages against the co-respondent.

AT a meeting held on March 8, at which the Governor presided, the committee elected to carry out the scheme for the erection of an hospital for consumptives, stated that last year 320 cases were treated at the Melbourne Hospital. At the conclusion of the meeting subscriptions amounting to £1,600 were announced.

EDWARD JOHN WILSON, M.R.C.S. Eng., 1845, died at his residence, Rogers Street, Richmond, near Melbourne, on March 3, aged 67 years.

JAMES SMITH ADAMS, L.F.P.S. Glas., 1839, a colonist of 47 years, died at Northcote, near Melbourne, on February 12, at the age of 69.

A PRESENTATION of a very handsome Wedgwood dinner service was made to Dr. J. B. Backhouse, of the Alfred Hospital, on February 11, by the matron and nurses of that institution, on the occasion of his retirement from the office of Resident Surgeon. The patients of the doctor's special surgical ward also presented him with three beautiful vases as a mark of their appreciation of the doctor's care, attention and kindness.

DR. DAVID GRANT, of Port Melbourne, late Assistant Medical Officer at the Hospital for the Insane, Callan Park, near Sydney, has been elected lecturer on *materia medica*, medical botany, and elementary therapeutics at the University of Melbourne, vice Dr. John Williams, resigned.

A VERY serious accident occurred on February 9, to Dr. Herbert Lillies, of Armidale. While he was riding on horseback along High-street, Prahran, and passing the Orrong Hotel, the animal which he was riding shied and threw him under the wheels of a heavily laden dray, which passed over him. He was removed as quickly as possible to the Alfred Hospital, with which institution he is connected as a member of the honorary medical staff. On being examined, Dr. Lillies was found to have sustained serious injuries, his right thigh and arm having been fractured, and suffering from a severe shock.

DR. R. J. LOOSLI has commenced practice at Riversdale Road, Camberwell, a suburb 5 miles E. of Melbourne.

DR. PAT. MOLONEY has returned to Melbourne from his visit to Europe, and resumed practice at his residence, 106 Collins-street East.

DR. W. L. MULLEN of South Melbourne, has been appointed Surgeon on probation, in the Victorian Militia, with the relative rank of Captain.

DR. JAS. ROBERTSON, one of the honorary physicians of the Melbourne Hospital for the last 26 years, has resigned.

DR. R. E. WEIGALL, of Northcote, has resigned his appointment of Assistant Surgeon in the Victorian Naval Forces.

DR. W. S. R. WOODFORDE has succeeded to the practice of the late Dr. Fulford, at Penshurst, in a pastoral and agricultural district, 181 miles W. of Melbourne.

WESTERN AUSTRALIA.

DR. N. W. HOLMES, late district medical officer at Guildford, has commenced practice as a general practitioner at Perth.

DR. H. J. BIRMINGHAM, a recent arrival, has settled at Fremantle.

DR. D. KENNY, of Perth, has resigned his commission in the Western Australian Volunteer Force of Surgeon.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards : -

NBW SOUTH WALES.

- Shand, John Cappie, M.B. et M.S. Glas., 1877.
Henry, Thomas James, L.F.P.S. Glas., 1886; L.R.C.P. Edin., 1886; L.R.C.S. Edin., 1886.
Nicholls, John William, M.D., Q.U., Irel., 1873; M. Ch., Q.U., Irel., 1873.
Young, Richard Weekes, L.S.A. Lond., 1886; M.R.C.S. Eng., 1886.
Cockie, Austin John, M.B., Trin. Coll., Dub., 1881; Ch.B., Trin. Coll., Dub., 1882.
MacLoughlin, Thomas James, L.R.C.S. Edin., 1878; L.R.C.P. Edin., 1878.
Haynes, Edward James Ambrose, L.R.C.P. Lond., 1886; M.R.C.S. Eng., 1886.
Heard, Charles de Wolfe, L.R.C.P. Edin., 1881; L.R.C.S. Edin., 1881.
Yeates, Edward, L. et L. Mid. K.Q.C.P. Irel., 1886; L.R.C.S. Irel., 1886.

TASMANIA.

- Dickenson, Augustus Newton, L.R.C.S. Irel., 1879; L.K.Q.C.P. Irel., 1880.

VICTORIA.

- Macansh, William, L. et L.Mid. R.C.P. et R.C.S. Edin., 1885; L.F.P.S. Glas., 1885; M.B. et Ch.M. Edin., 1886.
MacColl, Donald Stewart, M.B. et Ch.M. Glas., 1886.
Barr, Thomas James, L. et L.Mid. R.C.P. et R.C.S. Edin., 1886; L.F.P.S. Glas., 1886.
Inglis, Edgar Montgomery M.B. et Ch.M. Edin., 1886; L. et L.Mid. R.C.P. et R.C.S. Edin., 1886.
Woodforde, William Sidney Ridout, L.S.A. Lond., 1884; M.B. et Ch.M. Edin., 1886.

WESTERN AUSTRALIA.

- Birmingham, Herbert Joseph, L.R.C.S. Irel., 1880; L. et L.Mid. K.Q.C.P. Irel., 1881.
Dunlop, John Bryce, L.R.C.S. Irel., 1881; L. et L.Mid. K.Q.C.P. Irel., 1882.

MEDICAL APPOINTMENTS.

- Anderson, Charles Morton, M.R.C.S. Eng., to be additional Public Vaccinator for the district of Christchurch, N.Z.
Dunlop, John Bryce, L.R.C.S. Irel., L. et L. Mid. K.Q.C.P. Irel., to be Government District Medical Officer at Northam, W.A.
Dyring, Carl Peter Wilhelm, M.B. Melb., to be Health Officer for shire of Coburg, Vic., vice Dr. W. H. Cutts, Jr., resigned.
Griffiths, Ernest Edward, M.R.C.S.E., L.R.C.P. Ed., to be Government Medical Officer and Vaccinator for the district of Blayney, N.S.W.
Hassell, Gray, M.B. et Ch.M. Aberd., appointed Resident Medical Officer at the Wellington Hospital, N.Z.
Hayden, James Augustus, M.R.C.S.E., to be Health Officer for shire of Dimboola, Vic.
Lawson, George Langrigg Leathes, L.R.C.P. Edin., M.R.C.S. Eng., elected Medical Officer of Bairnsdale Hospital, N.S.W.
MacGregor, Duncan, M.B. et Ch.M. Edin., to be a Member of the N.Z. Central Board of Health, vice Dr. Graham, resigned.
McLennan, Warwick Guy, L.R.C.P. Edin., M.R.C.S.E., to be Public Vaccinator at Kyabram, Vic.
McMurry, Wahab, M.D., et Ch. M. Qu. Univ. Irel., appointed Medical Officer to Walgett Hospital, N.S.W.
Miles, George Edward, M.R.C.S.E., L.R.C.P. Lond., to be Assistant Medical Officer of the Hospital for the Insane, Callan Park, Balmain, Sydney.
Neill, William Napper, M.B. et Ch.B. Dubl., to be Assistant Resident Medical Officer at the Women's Hospital, Carlton, Vic.
O'Doherty, Edward Hyacinth, M.R.C.S. Irel., L.K.Q.C.P. Irel., to be a Surgeon in the Queensland Defence Force.
Fairman, Thomas Wyld, L.R.C.P. et R.C.S. Edin., to be Public Vaccinator for the district of Te Awamutu, N.Z.
Robinson, Archibald Clarke, M.D. Qu. Univ. Irel., L.R.C.S. Edin., to be Health Officer to shire of Grenville, Vic.
Smith, John Govett, M.R.C.S. Eng., to be Additional Public Vaccinator for the district of Lower Clarence River, N.S.W.
Whitehead, Arthur Meredith, M.B. et Ch.M. Aberd., to be Honorary Surgeon of the Petone Naval Artillery Volunteers, N.Z.
Wood, Arthur Jeffrey, M.B. et Ch.B. Melb., elected Resident Medical Officer to the Melbourne Hospital for Sick Children.
Woodforde, William Sidney Ridout, M.B. et Ch.M. Edin., to be Public Vaccinator at Penshurst, also Health Officer to the shire of Mount Rouse, Vic.

REPORTED MORTALITY FOR THE MONTH OF JANUARY, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from							
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phtisis.	Heart Disease.
N. S. WALES.												
Sydney	135,000	335	200	113	...	...	3	2	8	16	17	12
Suburbs	200,000	749	415	313	...	2	8	7	16	40	26	8
NEW ZEALAND.												
Auckland	33,161	97	33	16	...	...	...	1	2	9	1	2
Christchurch	15,265	30	10	2	...	...	...	...	1	2	3	1
Dunedin	23,243	56	25	9	1	1	...	...	...	1	3	1
Wellington	25,945	94	40	19	...	...	...	...	12	2	4	1
QUEENSLAND.												
Brisbane	32,571	104	59	37	...	4	4	4	8	22	5	3
Suburbs	41,082	188	83	49	...	...	...	...	...	...	...	2
SOUTH AUSTRALIA.												
SOUTH AUSTRALIA.....	318,785	808	452	229	...	1	2	8	19	75	27	21
Adelaide	45,383	92	67	16	...	1	1	1	4	7	8	5
TASMANIA.												
Hobart	29,851	98	61	37	...	...	...	1	5	13	3	8
Launceston	18,887	56	40	25	...	...	...	...	1	8	2	3
Hospitals, Asylums, Gaols, &c. .	1,268	...	37	...	...	...	...	...	...	...	...	...
Country Districts.....	87,380	244	85	...	...	...	...	1	...	19	...	...
VICTORIA.												
Melbourne	69,774	161	134	511	8	4	8	40	149	82	47	20
Suburbs	275,606	1,048	822	511	...	...	...	...	...	...	...	39

METEOROLOGICAL OBSERVATIONS FOR JANUARY, 1887.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Inches	Depth.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	111.2	75.6	51.1	29.750	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	146	81.5	70.8	58.5	...	1.290	5	78	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	...	92.5	76.6	64.2	29.854	23.334	17	72	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	...	...	...	...	...	1.414	6	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	103.6	66.1	46.7	29.855	3.43	13	77	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	...	96.1	71.3	45.1	29.891	2.11	8	66	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	...	104.9	69.1	47.9	29.808	1.11	6	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.	86.6	73.2	61.6	29.908	6.30	19	78	...	N.E.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 26" E.....	143	83.1	67.2	47.1	0.176	3	78	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

RICINUS COMMUNIS.

BY THOMAS DIXON, M.B., CH.M., LECTURER UPON MATERIA MEDICA, UNIVERSITY OF SYDNEY.

[Continued from Page 188.]

THE AUTHOR'S INVESTIGATIONS.

FROM the preceding resumé it will be seen that we have no satisfactory conception of the nature of the purgative substance or substances in the castor oil seed.

During the year 1883 this subject was taken up by the late Dr. Bübnov, who worked at it for a while in the Laboratory of Professor Schmiedeberg (Strassburg). But some time afterwards succumbing to a severe illness that gentleman left no account of his method. The only facts which could be gleaned were, that by means of an acid acting upon the seeds, prepared as below, he obtained a solution; from this the precipitate, caused by adding an alkali, when dried shewed the activity of the original castor seed. He concluded, it seems, that this substance gives the activity to the oil.

It must be remembered then that Bübnov was the first to obtain in a *dry form* an active extract from the castor seeds. It will be seen, however, that (1) this was no more than a very impure substance, which could be obtained *more simply and better* in the way to be presently described; (2) the conclusion as to the connection between oil and seed was incorrect. My first attempt was to find out the details of Bübnov's method. The castor oil seed, carefully shelled from the husk, was crushed and washed for four or five days on a filter with alcohol and ether alternately till *no trace of oil* was noticeable upon evaporating the percolating fluid. The residue was a fine, dry, white *meal*, of no smell and pleasant taste.

When five grammes of the *shelled seeds* in the natural state were powdered and emulsified with gum arabic and given to a rabbit no effect was visible till 15 hours after, when diarrhoea of dark green fluid motions in great amount occurred, the animal dying about five hours after. The *P.M.* examination shewed that the gall-bladder contained a little dark bile; the oesophagus was healthy; stomach slightly reddened outside and in at the greater curvature; from the pylorus downwards the small intestine was reddened, the color increasing in intensity and shewing *extravasations* also increasing in size; *Peyers' patches*

were swollen and pale on the mucous surface, but *very red* upon their *subserous* one. At the lower end of the small intestine was a black purple patch sharply defined; the cæcum at the inner (proximal) end was red and full of dark, greenish brown, porridge-like material, the blind third being pale and full of a yellowish fluid. The small intestine was full of a yellowish semi-transparent fluid, interspersed with greenish flakes; the large intestine was nowhere reddened; the mesenteric glands were *very dark red and swollen*; heart, brain, bladder, &c., were normal, and apparently also the kidneys. The duodenum, at about the entrance of the bile duct was *intensely purple*; this color fading slowly up to the stomach and quicker downwards; after this the color increased, as said before, till at the spot mentioned above where there was the second dark purple patch.

The *castor powder or meal*, prepared as already described and given in five grammes doses, was *identical* in effects, but the death occurred about three hours sooner, and the purple spots were darker, &c.; sometimes the cæcum had transverse linear *extravasations* on its *subserous* surface.

"*Bübnov's Extract.*"—In my endeavour to find the method of making this, 20 grammes of the castor meal were let stand in 500 cubic centimetres of a 5% solution of anhydrous hydrochloric acid. This slightly opalescent acid solution was filtered and then precipitated with carbonate of soda. The white flakes which formed were filtered and washed with water and then with alcohol. The result was a white cake, which became grey and horny on keeping; it was quite *inert*. The process was repeated with fresh meal—each time a weaker and weaker solution of acid being used. When a 1% solution of absolute acid was used the *meal* was found to retain some *activity*, though the *extract* was *inert*. A $\frac{1}{2}\%$ acid yielded an *active extract*, so also a $1\frac{1}{2}$ per mille acid; of this latter $\frac{1}{2}$ gramme given a rabbit *acted like the seeds*.

A quarter of a gramme *injected hypodermically* into a rabbit caused a *slight diarrhoea*, and it died on the second day. The intestine was not very injected, but the *extravasations* on its wall, and on the cæcum (and colon too), in the *mesentery*, and its *glands* were more marked. The two specially chosen spots under the administration by mouth were almost unaffected (*i.e.*, duodenum and lowest end of small intestine); a few slight *effusions* were seen in the *lungs*; one or two large ones in the front of the *neck*.

Two-thirds of a grain produced similar effects, but the stomach was slightly inflamed; the duodenum about the orifice of the "*common duct*"

red ; the colon slightly inflamed at its first third, and its lower part filled with a clear, *stiff gelatinous material* ; the lymphatics of neck and axilla much congested.

When the hydrochloric acid was rendered weaker in the process of preparing the extract no precipitate could be got by the carbonate of soda. Further, whatever the time used for the extracting with acid the residual meal always shewed great energy.

"A better Method of obtaining the Extract."—It has been seen that moderately strong acid yielded an inert body in great amount, and a very weak acid yielded nothing, and yet the residue was still active if the acid were not too strong ; hence it was probable that the principle was dissolved in the water, and that the acid was merely a solvent for albumen which the alkali precipitated, the precipitate carrying down some of the dissolved acting principle with it, and that if the acid was strong it made plenty of acid albumen (but killed the active body) and so yielded plenty of precipitate (inert "extract"), and that if weak it made little acid albumen, and gave no precipitate at all.

But as the meal was quite unsuitable for making solutions from, as they filtered badly, some "castor cake" was ordered from Italy and obtained through Dr. Phillips, apothecary of Strassburg, to whom my thanks are due for his great attention in procuring me these materials. This castor cake is merely the residue of the whole-crushed seed after the expression of the oil for commerce. It is exceedingly energetic in action, of not unpleasant smell, and, as will be seen presently, were it made from husked seeds would be, after boiling, a pleasant enough food.

I took this "cake" and rubbed it up with an equal bulk of water, let it stand a few hours, and finally squeezed out the fluid in a press. The resulting liquid was filtered carefully ; but, as it did this very slowly and imperfectly, it was found best to let it settle over night, and then filter the yellow supernatant syrupy fluid through filter paper. The result was a clear yellow fluid of great energy. On adding alcohol a coagulum formed at once, which, on adding five times as much, 98%, alcohol ("absolute alcohol") was all precipitated. Hence we can see why Werner failed to find this body ; for it is not precipitated in a large amount of weak alcohol unless present in large amount itself. But this precipitate is always very energetic. Like Bübnow's, it is very full of albumen ; it also gives the reaction of a glycoside ; when dry it forms a horny yellow mass. The question now was how to purify it. In this all attempts failed, but certain interesting facts were brought out. This precipitate never would retain its activity after heating in water for one

instant at the boiling point, and copious precipitate of albumen formed. The seeds when merely heated in alcohol, even to its boiling point, were rendered inert.

When treated for an alkali acid or glycoside in the usual way no active substance was obtainable from the "precipitate." Even when attempts were made to fractionally precipitate with alcohol no distinct difference in activity was appreciable between the first and last bodies obtained.

Repeated precipitation with alcohol certainly took more and more yellow coloring matter into the alcohol but, unfortunately, the precipitate previously soluble in water became each time partly insoluble in water, till at last only a trifle of a white powder, soluble in water, but inert, was left, the rest remaining on the filter as a partly active, sticky, albuminous body. Filtration was always very slow, and if the time occupied extended over two or three days the fluid putrefied.

The only approach to purification was on precipitation with basic acetate of lead ; acetate of lead itself merely rendered the solution unfilterable, but if a few drops of ammonia were added a filterable product, quite transparent and colorless, was obtainable, which, when precipitated by alcohol, gave a colorless, flaky deposit, also very active. But this, as before, always contained albumen, was only obtainable in small amount, and even then only occasionally, as the amounts of the lead and ammonia had to be correctly chosen, otherwise all was precipitated.

THE GLYCOSIDE.—This can be isolated in a method suggested by Professor Schmiedeberg :—Wash the "oil cake" with acetic acid ; for several hours filter ; precipitate the filtrate with chloride of calcium and an alkali ; the result is a yellow, bulky precipitate, which is washed with an alkaline solution. This process is repeated several times, till the alkaline solution no longer shows any trace of albumen, nor yellowness from coloring matter as it passes through. At last there is nothing left but the white precipitate of the lime and the lime glycoside salt, but no albumen. To get the glycoside away, precipitate with sulphuric acid exactly ; the glycoside dissolves in the water and can be filtered from the lime sulphate ; for greater exactness, the last traces of lime are, of course, best got rid of by oxalic acid. The glycoside on solution shews some resemblance to the "crude precipitate" from the cake (except that it is inert), for it is precipitable from water by great excess of alcohol and ether, but the ether is needed for precipitating it fully. The result is a white, amorphous, albuminous-looking body, which I have not yet had the chance further to investigate, but it explains how Ritthausen thought there were albuminous glycosides in

this seed. We are thus placed in the same position as regards this body that we were till lately as regards the active principle of that commonest of drugs, Senna; the active principle of which, even to the present day, has not been obtained pure, it being so unstable.

CASTOR OIL: What relation does the above principle hold towards castor oil? A comparison of their actions shews no resemblance whatever between them.

Although the above *active principle* is soluble in water, not in alcohol and ether, and is decomposed by heat below the boiling point of water, yet *castor oil* shaken up with water, or shaken up with alcoholized water, yields to these *no active principle* whatever; to boil castor oil with water for hours only gives it a disagreeable taste, but does not affect its activity by increasing or decreasing it. It might be said that the presence of water is necessary to aid the action of the heat on the active principle alleged to be dissolved out of the seed by the oil.

Against this, there are the further facts (1) that olive oil kept for days, hot or cold, in contact with the seed meal never becomes specially purgative; (2) that the already mentioned physical relations to water, &c., speak against the theory; (3) that oil, boiled with a little water and alcohol, dissolves them *both*, but in no way loses its activity, as the seeds would; and finally that the *physiological action of the seeds* is quite unlike that of the *oil*, as is to be seen from the following:—

If castor oil be given to a rabbit in a dose of 25 grammes it will cause a violent diarrhoea, killing the animal in two or three days; a corresponding dose (5 grammes) of the seeds necessary to kill in the same time, or even more slowly, causes also diarrhoea, but the *P.M.* signs are *quite different*. The oil has caused *not a trace of congestion* anywhere, the intestine being full of a slightly muco-purulent looking fluid, as it might be described; but the seeds, even if they kill more slowly, always shew signs of *excessive inflammation* extending into the large intestine even. In short, the oil seems to be a *stimulant of the mucous glands*, and causes death by exhaustion from the flux, the seeds to be *general irritants* (or, perhaps, acting upon the vascular pressure in the manner of arsenic).

Although ricinoleate of magnesia or soda is aperient, the ricinoleic acid is not, and the action must be due to the *base*. It is true that, as regards the castor oil, one can imagine that the glycerine set free from the oil acts as an aperient; if so, why does not olive oil act so too? The only conclusion possible seems to be that the oil contains an active, oily (or resinous?) substance.

This is not the resinous body which deposits in the oil on keeping, for it is *inert*.

Demaria and Parola's statements about the oil got by ether, &c., being stronger, cannot possibly be correct, for I never saw in such oil any approach to the strength that they assert; it was identical with the commercial oil in strength. The ground of their statements probably is due to the oil not having been filtered through paper (*they only mention cloth*). Now I found that cloth was not sufficient, and that the very slight trace of the seeds which got through greatly enhanced the *purgative action*, but this was removed at once on passing it through filter-paper.

CONCLUSIONS.—From the above we can see that some of the investigators have been led astray, and so brought about incorrect impressions as to the nature of the contents of the seeds and their action, and we may put shortly the conclusions from the above investigations:—

- That the castor oil contains only a gentle aperient, while the castor seeds contain a violent, irritant one.

- That the seeds should never be used as is done in some countries by the "herbalist," as aperients, *deaths in great agony having been so caused*.

- That in castor oil the aperient substance seems to be an oil or resin, and is certainly not the same body which we find in the seeds, after the oil has been extracted, as stated wrongly in text books.

- Nauseous material can get into the oil through it being heated, or through it being expressed from the *unshelled* seeds; for the unshelled seeds yield, to alcohol or ether, a brown substance of *ill smell* and acrid taste, but *not aperient*.

- That if the seeds were shelled before the oil were pressed out cold, an almost tasteless oil is got, while the cake left behind would, if *cooked*, form an albuminous, pleasant article of food, especially of use in India, where *thousands of tons* of the cake are made yearly in a crude way. In *famine*, this would be a *valuable adjunct* to rice, seeing that meat is not eaten by Hindoos.

- That the active principle is probably the very glycoside found in the seed, which, through a slight change in chemical composition (hydration perhaps), loses its activity (c.f. Convolvulin, which readily changes when heated in presence of alkalies to the inert convolvulinic acid).

The leaves of the castor plant have been long used locally, for encouraging lactation. I was unable to obtain any traces of an active principle either aperient or otherwise from the fresh leaves; possibly the benefit may be due to their being large, soft and pliable, and so suitable for covering the surface well and closely and encouraging local warmth as non-conductors.

[As will be seen from the foot-note of the author, the following paper has already been published in the Australian Medical Journal, though against the express wish of the author, and moreover in so mutilated a manner that Dr. Pinnoch has requested us to republish the same in its original form as read before the Melbourne Branch of the B.M.A. It having been the author's desire to have his paper published only in the Gazette, we, under the peculiar circumstances of the case, have made an exception in our rule never to publish any article that has appeared in a local journal.—ED. A.M.G.]

OVARIOTOMY IN A PATIENT AGED 67 YEARS—RECOVERY.

BY ROBERT DENHAM PINNOCK, M.B., CH. M.,
UNIV. GLASG., OF BALLARAT, VICTORIA.

MRS. H., at. 67, a small spare woman, was first seen by me on the 17th August, 1886, for an attack of acute peritonitis, and the tumour was then discovered. The peritonitis had apparently been set up by a blow on the abdomen from the handle of her mangle. As soon as the inflammatory symptoms had subsided, viz., 21st August, I aspirated the tumour, and drew off 144 ozs. of viscid reddish-brown fluid of sp. gr. 1030—neutral reaction—containing much albumen. Under the microscope the fluid showed a quantity of cholesterine crystals, and numerous granular cells without nuclei (Drysdale's cells), also red corpuscles. The tumour receded very slightly after tapping, giving rise to the suspicion—afterwards verified—that extensive adhesions existed.

The patient was born in England, widow for last 17 years, earns living by mangling, four children, all living and well, youngest at 20, never miscarried. Climacteric passed with good general health at 50 years of age. Married at 33 years. Confinements all natural. Parents both died of old age; father at. 75, and mother at. 92.

When 20 years old her abdomen gradually enlarged without pain or interference with her general health, though its weight and bulk naturally prevented her from getting about. When 22 years old she was tapped at Carlisle, by Dr. Barnes, who said she had dropsy, and took away 15 quarts of quite clear and colourless fluid. She had no chloroform, and saw the fluid. The abdomen never enlarged again until the present occasion, and with these two exceptions she has enjoyed good health all her life.

The present enlargement was first noticed two years ago, sometimes in one flank and sometimes in the other; but she only observed the abdomen enlarge in front about three months before the attack of peritonitis. She never suffered pain,

and was at work up to the date of the peritonitis. Heart, lungs and liver healthy. Urine pale amber. Slight flocculent precipitate, sp. gr. 1010 acid, no albumen. After the tapping on the 21st August, she was fed up and given tonics, and not allowed to work.

On the 20th September the cyst having filled up again, I operated at 4 p.m. in our private hospital; Dr. Eastwood administering bichloride of methylene, and Drs. Hudson, Ochiltree, and Salmon kindly assisting. Median incision 4 inches long between umbilicus and pubes. Almost the whole surface of the tumour was adherent to omentum, intestines, bladder, and brim of pelvis. Some of the adhesions being recent were broken down without much difficulty. Others were so firm that great care and patience were required to separate them; but, by sacrificing the outer coat of the sac wall in some places, cutting between double ligatures in others, and using the thermocautery where required, the cyst was eventually removed after emptying it with a Wells' Trocar. The pedicle was secured with strong carbolised hemp, and dropped into the abdomen. It gave no trouble, being long and thin. It sprung from the left broad ligament. I endeavoured to examine the right ovary, but could not find it. After carefully cleansing the abdominal cavity and intestines, and checking all oozing, the peritoneal incision was secured by a continuous over and under suture of fine carbolised gut, and the abdominal incision by five deep sutures of carbolised hemp, and a few intermediate superficial ones of carbolised silk. The operation was not performed under the actual carbolic spray, but a steam spray was playing in the room before and during the operation. The wound having been well dusted with iodoform, was covered with a dry strip of boric lint, and over this a pad of salicylic wool, the whole being secured by a broad bandage of soft flannel. The tumour was unilocular, and with its contents, weighed rather over 9 lbs. Owing to the trouble with the adhesions she was not in bed until 5.30 p.m.; 1½ hours after being anaesthetised, and was then suffering greatly from shock, the pulse being 60, very weak and small, temp. 94. Surface and extremities quite cold, and respiration shallow. A self-retaining catheter was left in the bladder. She was wrapped in hot blankets, and hot bottles applied to every available part. Small quantities of hot brandy and water given frequently, and strong ammonia to the nostrils, until she gradually rallied, and by 9.30 p.m., the pulse was 92, regular and firm; temp. 98.6. Is occasionally delirious and wants to pass water, though the urine comes away freely through the catheter. Tongue clean and moist. No special thirst.

Slight vomiting of bile-stained fluid. Says she has no pain and feels warm and comfortable. Had $\frac{1}{2}$ gr. morphia and $\frac{1}{10}$ gr. atropia hypodermically. To have barley-water and mucilage only.

21st.—P. 96, regular, hard; T. 99.3. Tongue dry. Very thirsty. Occasionally delirious. Slight bilious vomiting on three occasions; flatulent colic twice. Slept at intervals last night.

22nd.—Slept well. Passed quantity of flatus at 5 a.m. No pain since. P. 88, regular, soft; T. 98. Tongue clean and not so dry. Thirst much less. No sickness.

23rd.—P. 100, regular, firm; T. 98.2. Tongue clean and moist. Slept well. No pain. Is hungry. To have beef-tea and raw egg in milk.

24th.—Doing well. Changed dressings. Wound united in entire length. Only very slight sero-sanguous staining on boric lint. Removed catheter this morning, but water required drawing off at midnight.

25th.—Doing well, but required to use catheter.

26th.—Doing well. Micturates at will.

27th.—All sutures removed. Perfect union.

29th.—Bowels moved for the first time since operation by enemata, and she is now to have a little solid food.

She continued to do well and returned home 2nd November. I see her occasionally, and she says that she is in excellent health and gaining flesh and strength every day. Is able to do her work, walk out, and is in no way invalided.

The pulse-rates and temperatures given are in each case the *highest* recorded during the 24 hours, three observations being made daily.

Is it not probable that the dropsey for which she was tapped 45 years ago, and which she states gradually increased for two years without any impairment of the general health, and which *never returned* after the withdrawal of the "quite clear colourless fluid," was a Parovarian cyst?

The patient, Mrs. McL., at. 53, from whom I removed a multilocular semi-solid ovarian tumour, weighing over 16 lbs. on the 3rd March, 1886, and whose case was read before the B.M.A. in April, 1886, is at this date in excellent health.

AUTHOR'S NOTE.—This paper read before the Melbourne branch of the British Medical Association, was published (in spite of my express desire to the contrary, as I wished to send it to the *Australasian Medical Gazette*) in the Australian Medical Journal, and then in so mutilated a form as to be practically valueless for statistical purposes. I now forward it to the *Gazette* with the request that the rule against re-publication from local journals may be so far relaxed under the peculiar circumstances of the case as to admit of its publication in its original form in the *Australasian Medical Gazette*.

CASE OF ACUTE OSTEO-MYELITIS, NECESSITATING DISARTICULATION OF HUMERUS—RECOVERY.

By J. S. HAYES, M.D., &c., TEMUKA, NEW ZEALAND.

G.T., a spare, delicate, strumous, seven months child, at. 12 years, was brought to me on 19th Nov., 1885, for a painful red swelling of left shoulder. On examination, I found the bone much thickened and exquisitely tender. His father thought it might have been sprained, but I could elicit no distinct history of any injury. The pain and swelling had come on suddenly. Warm opiate fomentations were applied, and arm painted afterwards with iodoform and collodion. About a fortnight after the acute symptoms of pain, redness and swelling almost entirely subsided in the shoulder, leaving the bone, however, still thickened. Left knee, left great toe and lower part of vertebral column now became the seats of red, painful swellings.

The pain and swelling soon reappeared in shoulder, spreading down arm into elbow-joint. The inflammation now subsided considerably in, but did not quite leave, toe and back. The swelling in knee and elbow-joint rapidly increased, and fluctuation was felt in both joints.

Dec. 18th.—The patient having been anaesthetised by Dr. Hogg, I opened knee-joint and gave exit to large quantity of glairy, semi-purulent fluid. The articular ends of tibia and femur seemed healthy, but the patella was hopelessly diseased, I therefore dissected it from the ligamentum patellæ and removed it, thoroughly washed out joint with carbolic lotion, made counter-openings and inserted drainage tubes in both sides; the limb which had become drawn up and flexed was straightened and put on a back splint.

On making incisions into elbow and evacuating pus the articular end and shaft of humerus were found to be very much diseased, being denuded of periosteum and articular cartilage eroded, radius and ulna seemed healthy, the joint, of course, was hopelessly disintegrated. The condition of patient did not warrant any further operative procedure that day, so, having made incisions and counter-incisions, drainage tubes were inserted and the arm was left.

The knee progressed favourably and ultimately healed with, of course, a stiff joint.

The elbow-joint, as expected, went from bad to worse, discharging freely pus of a most offensive character. Abscesses formed in the arm, which soon became undermined by sinuses in all directions. Unmistakable symptoms of pyæmia now manifested themselves. Pulse, 134; exacerba-

tions of temperature—sweating, shivering, &c. Boy very weak and exhausted.

I had spoken to the parents previously about amputation, but they were unwilling at first to consent. I now represented to them that things had come to such a pass that the boy must die unless amputation was performed, and that I regarded operation now as almost hopeless, but that it was the only chance of saving life; further, that the boy was so much exhausted that they must not blame me if he were to die on the operating table. Finally they consented to the operation.

Jan. 16th, 1886.—The boy having been chloroformed by Dr. Hogg, I commenced the operation for disarticulating the humerus, the necessary incisions for which had to be made through diseased and suppurating tissues, pus welling up as the incisions were made, and burrowing not only through the tissues of the arm but also across the axilla and extensively under the pectoralis muscle on the chest. During operation three vessels were tied and several twisted; drainage tubes were inserted in arm and chest; wound sutured with catgut (chromized.)

On examination of humerus after removal, the bone was found to be diseased in its entire length, being quite dead, dark in colour, bare, rough and honeycombed, breaking like a rotten stick.

Twice during the operation we thought the boy was dead, but was almost miraculously brought to by artificial respiration—applying very hot water over heart, inhalation of ammonia and nitrite of amyl.

One of my lay assistants, thinking the boy had expired, overcome by his feelings, had to leave the room, was much surprised on his return to see him breathing again.

After operation patient was collapsed and condition most desperate—cold extremities, pulse barely detectable. Rallied a little during night.

Jan. 17th, next morning.—Pulse, 185; T., 100; vomiting; ice to suck prescribed.

18th.—P., 188; T., 101; dressed wound; feels better.

19th.—P., 136; T., 100 $\frac{1}{2}$.

20th.—P., 100; T., 100 $\frac{1}{2}$.

22nd.—P., 185; T., 99 $\frac{1}{2}$. Takes a fair amount of nourishment; sleeps well; has only required one opiate, viz., on night of operation.

The wounds, which were discharging freely, had to be washed out daily with glycerine and boracic acid lotion. Dressings: Iodoform, wool and tenax over boracic acid on lint.

The first ligature came away on the 18th day and the stump was healed in five weeks. Shortly after this I left home, and on my return, after an absence of a month, I found that the left great toe and some of the tarsal bones were exhibiting signs of disease.

March 26th, 1886.—Assisted by Dr. F. C. Singleton, my *locum tenens*, I cut down on the bone, removed a sequestrum from the tarsus, and with the gouge scooped out a quantity of detritus, leaving the metatarsal bone of great toe a mere shell. I may mention iodoform was largely used, and proved of great utility, in all the dressings of this case.

The operation on foot did well, healing rapidly, and ultimately the boy recovered and was able to get up and move about—at first with a crutch and afterwards with the aid of a stick.

Fortunately the inflammatory action did not reappear in bones of vertebræ.

My best thanks are due to Drs. Hogg and Singleton for their very able assistance in this trying case.

FOETAL MONSTER.

By J. C. VERCO, M.D. LOND., F.R.C.S. ENG., L.R.C.P. LOND., ADELAIDE, S.A.

Mrs. R., at 34, native of Yorkshire, has been in the colony four years. Had no sign of the menses till she was 21 years of age. When they appeared they came regularly until she was married. The periods have always been scanty, and extremely painful. Her pain would begin nearly a week before the menstrual flow, and generally compelled her to take to her bed at once, and keep it until the period had ceased, so that often she was two weeks in bed and sometimes three. Her last menstrual period ceased on April 25th, 1886, due to her first pregnancy. From Oct. 11th to Oct. 25th she was under treatment for very severe abdominal pain with feverishness, supposed to be due to uterine inflammation, although unattended by any peri-uterine deposit. From this she completely recovered.

On Dec. 1st, 1886, at about midnight, she was seized with labour pains, and was seen by me at 3 a.m., when a small foetal head presented. At about 4.15 a.m. a male child was born, perfectly formed, but small, and alive. A second amniotic sac was now found, and on rupture discharged an abnormally large amount of fluid. Then a body was felt, something like a diminutive foetal pelvis, with a soft pendulous mass simulating the genitalia, but no testes or penis could be distinguished, nor could the details of a breech presentation be recognised; so a diagnosis of monstrosity was made, and with very little difficulty the accompanying monster was expelled. The two placentæ were united, and one, apparently that belonging to the monster, was adherent to the lower part of the back wall of the uterus. The cord of the monster was not more

than an inch and a half long, that of the perfect child was of about the normal length.

The monster is about 6 inches long and $3\frac{1}{2}$ broad, and weighs a pound and an ounce. It is pear-shaped, and where the stalk should be are two diverging finger-shaped processes, one being about twice the length of the other. The lower two-thirds are quite smooth and rounded, and destitute of any evidence of organs externally. At the junction of the upper and middle third in the median line is the umbilical cord. The third above this is divided into three unequal lobes in front. The central one, representing the head, has a large cavity in it bounded below by a fleshy lip, and on the left side by a thin fleshy cheek, and above by a soft red bleeding fleshy loose mass; on the right side, except at the lower part where it is separated by a deep sulcus, it is nearly on the same level as the adjacent lobe. This cavity contains on the apparent left a rounded cartilaginous mass (the right superior maxilla?). To the right of this a larger, rounded, soft, fleshy mass (? the tongue). Below this three cartilaginous nodules, the right one rather higher than the others (the two inferior maxillæ and the left superior maxilla?). Above the tongue a thin lid-like fold, with a mucous-looking lining—allowing a probe to pass some distance inwards between it and the tongue, but not into any continuous gullet.

The left lobe is large, separated from the middle by a deep sulcus, at the lower part of which springs the umbilical cord, and at the upper part of which is an aperture large enough to admit a No. 8 catheter (probably the right meatus auditorius). This apparent left lobe is probably the right upper extremity. There are, apparently, at least three joints in it, by flexion of which the limb is twisted upwards and backwards, so that a deformed hand, with four short fingers and a very rudimentary thumb lies behind the head. The upper part of this limb and the adjacent part of the head above the ear-hole is covered with short dark hair.

The right lobe is the smallest, and has a nipple-like projection about a quarter of an inch long, probably a rudimentary arm.

On examination from the top, by turning upwards and forwards the soft bleeding mass above the head, there is seen an irregular triangular surface, with the rounded apex down and back, measuring about two inches long, to which the fleshy mass can be somewhat accurately fitted, and from which it appears to have been stripped up.

There is nothing to be discovered of any rudimentary eyes: nor any external opening of the urinary or intestinal systems.

TYPHOID FEVER.

READ BEFORE THE MEDICAL SOCIETY OF QUEENSLAND, FEBRUARY 8, 1887.

BY F. W. E. HARE, M.B., M.R.C.S., RESIDENT MEDICAL OFFICER, BRISBANE HOSPITAL.

HAVING absolutely nothing original to say upon the subject of typhoid, I came to the conclusion that the most appropriate manner of opening a discussion upon it would be to submit for your consideration an analysis of the cases which came under treatment at the hospital during the period of one year. In recording cases for statistical purposes it is essential that negative as well as positive facts should be noted, otherwise the results can hardly be considered reliable; but this I found to entail so much clerical work as to be impracticable, in the absence of anyone to undertake the duties of clinical clerk. I have, therefore, selected those facts chiefly which were recorded in the admission book and on the temperature charts. They relate especially to the predisposing causes and a few of the prominent symptoms, and are necessarily somewhat scanty. All I claim for them, however, is that they are fairly accurate.

There is a wide-spread impression that much of the fever which occurs in Brisbane is not real typhoid but rather a variety of malaria, and I have frequently heard medical men express the opinion that typhoid here runs a different course from typhoid in England—attributing this to some climatic or malarious influence. Ague, of course, occurs here as elsewhere, and I have seen one case, where the patient seemed to have ague and typhoid simultaneously. This would probably correspond to the typhomalaria of some writers. With this one exception, however, I have never seen a case of continued or remittent fever where it was necessary to assume the existence of any other factors in the causation of the disease than the typhoid poison. A large majority of the cases at the hospital agreed in every detail with the typical description of the disease given in every text book; nor, so far as I am able to discover, are the variations from this standard more frequent than at the antipodes. Moreover, an analysis of the principal features in the series shows practically the same results as were obtained by Murchison at the London Fever Hospital. This being so, it would, I am certain, be an unmixed benefit to banish, once for all, such indefinite terms as "slow" and "colonial" fever. There is far more in this than a mere question of nomenclature. The term "typhoid" is no doubt unscientific, but it has this advantage over all others—it is every day becoming more widely known by all classes, who understand by it

not only a serious but also a preventable disease. Again, nothing has a more damaging effect on hospital mortality than delay in seeking admission. This arises partly no doubt from want of proper nursing, but in great measure, I feel confident, to the excitement and fatigue of the journey to the institution during an advanced stage of the disease. But, whatever be the cause, the fact is apparent from the following figures :—197 cases came in during the first week of the fever ; of these 19 died, a mortality of 9.6 per cent., whilst of 215 cases admitted later than the seventh day, 36 died, a mortality of 16.7 per cent. I have on several occasions been told by patients, who believed themselves suffering from slow fever, that, had they known they had typhoid they would have come to the hospital at once.

The influence of season is well marked, the disease sustaining its reputation as an autumn fever, as will be seen from the following list of admissions :—In July, 1885, 18 were admitted ; in August, 12 ; September, 7 ; October, 20 ; November, 82 ; December, 42 ; January, 47 ; February, 67 ; March, 74 ; April, 67 ; May, 51 ; June, 48 ; July, 22. From these figures it is apparent, that in the early spring month of September, fever was at its lowest ebb. Then there was a gradual increase in the number of admissions through the following months up to February, when there was a sudden increase which attained its climax in March, and was maintained during the four autumn months.

This is exactly similar to what was observed at the London Fever Hospital, where 53.4 per cent. of the whole annual admissions occurred during August, September, October, and November. During last year's fever season at the Brisbane hospital, from July, 1885 to July, 1886, 52.5 per cent. of the whole number occurred during the corresponding months of February, March, April, and May. Still a further likeness may be traced in the fact that the disease does not immediately subside with the advent of winter, the cases during the winter month of June being more numerous than during the summer month of December, as if, as Murchison suggests, the cold weather, though powerful to kill the fever, took some time to act.

Recent residence exerts, as might be expected, a powerful influence. Of 472 cases where the date of immigration was noted, 195 had been in the colony less than one year, and of these, 136 not more than 6 months. I do not know the proportion that new chums bear to the general population. Taking, however, 1 to 25 as the proportion of residents of less than 6 months, to the whole (and this is probably excessive), the liability of one of these to contract typhoid would

be just 10 times greater than that of an average member of the community.

With regard to age as a predisposing cause, the statistics of 491 cases are even more significant. The period of life especially favored by typhoid, according to Murchison, is that between 15 and 25. 46.5 per cent. of the whole of his cases were between these ages. Last year at the Hospital 60 per cent. of the whole occurred during this period of life. This excess is chiefly due to the preponderance of cases between the ages of 19 and 25, and I think can be explained by the influence of immigration. Most of the new arrivals are young adults, not youths, and a very large proportion of them contract typhoid before they have been long in the colony. The same consideration may serve to explain the slight difference in the proportion of cases over 30 years of age, 18.3 per cent. being above this age at the London Fever Hospital, 15 per cent. at the Brisbane Hospital.

The question of the duration of typhoid brings up the usual difficulty in fixing the date of onset. Of 493 cases I found it possible to do this approximately in 315. In 299, however, there seemed little doubt as to the exact date of invasion, and of these the mean duration was 28 days. Murchison gives as the mean duration of 200 cases which recovered 24.3 days. The commonest day for the termination of the fever was the 21st, 29 cases lasting exactly this time ; next to this was the 22nd and 24th, 19 cases ending on each of these days. Many cases were prolonged much beyond this, and in two instances convalescence did not set in until the 82nd and 120th days respectively. These were no doubt cases of frequent intercurrent relapse. Eleven cases convalesced before the 10th day, and these I believe would not be recognised as typhoid by many English writers. That they were so I have but little doubt. Several of them came from houses where there were, or recently had been, cases of typical typhoid, and one of them had a brother in the male ward with an undoubted attack at the same time. I have recently come across two cases where the symptoms were very mild and the fever terminated early. After a few days of convalescence, however, they relapsed, the relapse running the course of a typical case of typhoid, accompanied with severe diarrhoea and an eruption of rose spots, although both of these symptoms had been absent from the primary attack.

Diarrhoea occurred in 248 cases out of 457, being absent in 209. Of 130 cases where it was present the average day for its appearance was the 10th. The importance of this symptom with regard to prognosis is plain. Of 58 fatal cases diarrhoea was present in 49, being absent in 8

only, and in 6 of these the average duration of the disease was only 15 days, the shortest being 11 and the longest 19, so that no fatal case which survived the 19th day was free from it. The mean duration of all fatal cases was 23·4 days.

Hæmorrhage occurred in 23 out of 457 cases, a percentage of five. The average day for its appearance was the 18th. In every instance but two it was preceded by severe diarrhoea. In these two it occurred suddenly on the 17th and 18th days respectively, and in both proved rapidly fatal by syncope. It seems to me, next to peritonitis, the most serious complication that can arise. Of the 23 cases 10 died, a mortality of 43·4 per cent., and in 7 of these death was directly due to syncope.

The frequency of relapses have been variously estimated by different authors, from 1·4 to 11 per cent. having been quoted. This may be partly due to variations in the character of different epidemics, but is chiefly accounted for, I think, by differences in opinions as to what constitutes a relapse. Of 498 cases, 42 had a distinct second attack, supervening after convalescence had commenced. These second attacks, or true relapses, were similar in all respects to the primary fever, being generally, however, less prolonged, 15·6 days being the mean duration. They were usually less severe, but not unfrequently more so; in 26 the primary fever was the more severe; in 13 the reverse was noted. As a general rule a severe primary fever was followed by a severe relapse, and *vice versa*. The occurrence or absence of diarrhoea during the primary fever seemed to have no influence on the liability to relapse; in 21 diarrhoea had existed, in 19 none, but several of these latter had diarrhoea during the relapse. In addition to these so-called "true relapses," in 29 other cases it was easy to trace the occurrence of a no less true relapse during the septicæmic or hectic stage of the primary fever before convalescence was established. The periods at which relapses occurred may be thus summarised:—

Before convalescence	-	-	29
During the first fortnight after	-	26	
second	"	-	8
After 3 months' convalescence	-	3	
" 5 "	"	-	1
" 7 "	"	-	1

so that the liability to relapse is greatest during the later stages of the fever and rapidly wears off after the first fortnight's convalescence.

Before estimating the mortality, I should mention that the treatment was in the main expectant, combined with occasional large doses of quinine as an antipyretic, and cold packs, though I rarely observed much benefit from these latter, as commonly applied.

Of 494 cases 62 died, giving a general mor-

tality of 12·5 per cent. 337 were males of whom 87 died, a percentage of 10·9. 157 were women of whom 25 died, a percentage 15·9. This includes all cases, some of which would be called febricula, and others that were moribund on admission. Excluding cases which became convalescent earlier than the 14th day, the general mortality would be about 14 per cent. This would again be reduced by excluding cases admitted in a dying condition.

The mode of death agrees in the main with what was observed at the London Fever Hospital. 15 cases died of perforation; none of these occurred before the 13th day, most of them being late in the disease during the 3rd, 4th and 5th weeks, or during a relapse; 14 died of exhaustion late in the disease, attended with considerable emaciation; 12 of cardiac failure or exhaustion earlier in the attack before much emaciation had taken place; 10 of pneumonia, with extensive consolidation of one or both lungs; 7 of syncope from hæmorrhage; 1 of epileptic convulsions, and 1 of apoplectic coma. This last patient became suddenly comatose, with stertorous breathing; after death many small subarachnoid haemorrhages were found. Upon most of these cases, *post-mortems* were made, so that they may be accepted as fairly accurate.

Besides the 62 cases where death was directly due to the fever or its immediate complications, 3 other cases died subsequently, the fatal result being indirectly due to the severe attack of fever through which they had passed.

The 1st contracted acute dysentery after convalescence and rapidly sank; the 2nd was readmitted into the Hospital 2 months after his discharge, suffering from peritonitis, which he attributed to a blow on the abdomen; the *post-mortem* showed rupture of the thinned base of an old ulcerated Peyer's patch.

The 3rd was readmitted 3 months after his discharge, suffering from serious cardiac symptoms, from which he died. The *post-mortem* showed simple dilation of heart. His attack of fever had been remarkable for its long sustained high temperature with severe delirium. No doubt the pyrexia caused softening of the cardiac muscle which subsequently gave way to the prolonged strain of the violent delirium.

With regard to treatment I have little to say. A considerable number of cases were put on *turpentine*, according to Professor Wood's formula. It did not seem to appreciably affect the mortality and it certainly did not prevent either hæmorrhage or perforation. It sometimes considerably lessened tympanites, but its most marked action seemed to be on the tongue and the secretions of the mouth. Dry, brown, and stiff tongues fre-

quently became under its influence moist and flexible, and thirst was much lessened. *Eucalyptus* appeared to act similarly, but was less powerful.

In cases with a tendency to cardiac failure, digitalis, ether, and alcohol gave the best results.

The only antipyretics I have tried have been quinine and salicylate of soda; the latter, in antipyretic doses, is too depressing in its action. Quinine is less open to objection on this account, but it often produces vomiting—to my mind a most dangerous complication. I have used it in doses of 30 to 40 grains in upwards of 150 cases, but I am not convinced that it is ultimately of undoubted benefit. It acts powerfully, as a rule, during the first week of the disease, before the temperature has obtained the upper hand, and during the later stages when morning remissions are "gain becoming apparent"; but it often fails when its action is most needed during the second and third week, when the temperature tends to pursue a continuous unremitting course. When it *has* acted and the temperature has again risen, the condition of the pulse has often seemed to me less satisfactory than before.

The cold pack for reducing temperature is of little value. I have seen patients in them for hours, and although the skin was cooled, I never found the temperature in the rectum appreciably affected.

The cold bath I have not used sufficiently often to speak as to its ultimate results on mortality, but I cannot understand how any one who has personally witnessed its immediate effects could refrain from giving it an extensive trial. Headache, restlessness, thirst, immediately disappear, and with the falling temperature the pulse, always much reduced in frequency, completely alters its character. It may have been soft, dicrotous, and irregular in force and rhythm. In every case I have noticed dicrotism disappears, and it becomes smaller, firmer, and more regular; in addition to which the patient, who may have been wakeful for days, almost invariably falls into a grateful and natural sleep, which lasts at any rate until the pyrexia has again returned.

There are of course many practical objections to the bath. The only one, however, which has seemed to me of any importance is the danger of inducing perforation during the necessary moving of the patient in a late stage of the disease. I have accordingly, in advanced cases, tried a modification of Dr. Kibbee's fever cot, which is described in Thomas's volume on Diseases of Women. It can be made almost as comfortable as an ordinary bed, is nearly as powerful as the bath in reducing temperature, and is far easier to use in the case of adults; besides which it is quite free from any danger of causing perforation as the

patient is never raised. I have brought with me a sketch which Mr. Keating, of the Hospital, has been kind enough to make, and which will demonstrate its mode of action more easily than any detailed explanation. I need not add that I shall be most happy to show it to any one present who cares to call at the Hospital.

SARCOMATOUS TUMOUR REMOVED FROM THE NASO-PHARYNX.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH
B.M.A.

BY J. DAVIES THOMAS, M.D., F.R.C.S.

The tumour handed around for inspection was removed by me, with the assistance of Dr. Lendon, on February 10, 1887.

The patient, a healthy girl of 14 years of age, had for a long time complained of inability to breathe through the nostrils, particularly through the left one. I first saw her for this cause in August, 1886, and then found by posterior rhinoscopy that a growth of considerable size projected downwards from the roof of the naso-pharynx. On the left side it touched the lateral wall of the pharynx, blocking the eustachian tube and causing middle-ear deafness on this side. On this side, too, the tumour extended into the posterior nares and occasioned complete blockage of the air passage. Repeated attempts were made to remove the tumour piecemeal, both by the nose and also from the naso-pharynx, but in time both the patient and I became wearied with the slow progress made, and it was decided to remove the entire tumour at one sitting under the influence of ether. As considerable haemorrhage was expected to accompany the operation the hanging-head position was selected and proved very satisfactory. With some little difficulty the base of the tumour was seized with Woakes's forceps, and after a few vigorous wrenches the entire mass was removed. It was attached by a short peduncular part to the base of the skull, just behind the septum narium. The base of attachment was nearly circular and about quarter of an inch in diameter. It, like the rest of the tumour, was remarkably tough and hard in consistence.

The weight of the growth was six grammes (a little over 90 grains). It consists of a pharyngeal and of a nasal part which differ much in their naked-eye appearance.

The pharyngeal part is rounded in shape and about the size of a Spanish olive; its surface is papillomatous and its colour reddish. The nasal portion is two inches long by three-quarters of an inch wide, and about quarter of an inch thick; it is dead-white in colour and perfectly smooth.

RECOLLECTIONS OF A COUNTRY PHYSICIAN.

BEING THE TRIALS, TRIUMPHS, AND DISAPPOINTMENTS OF PROFESSIONAL LIFE.

COPIED FROM HIS FATHER'S NOTES,
BY WALTER DUNN, B.A., CANT.; M.R.C.S.E.;
OF ROXBURGH, OTAGO, NEW ZEALAND.

III.

THEN I was startled by the splendid cures that Dieffenbach was making in strabismus, talipes, &c., and I went to Germany for instruction, and returned, finding plenty to do in this new field of practice.

I had patients from all parts of Yorkshire and Lincolnshire; I had very hard work, for although it is easy to cut a tendon, it is not so easy to cure an old standing case. I frequently repented of my confidence, but I succeeded in all my cases, cost what it might.

The cases of strabismus were legion, and a gentleman of the town threw off and published a *jeu d'esprit* in these words:—

"True, Dr. Dunn, you liberate the eye,
By fun or fortune placed awry;
But we in vain your lancet craft bespeak,
If once the moral sense is left oblique.
Henceforward, indebted to men like you,
The world will look straightforward, honest, true;
But the mind's eye, Horatio, baffles skill,
If once that organ squints, it always will.—G.M."

The operation for squint is one very easy, and not painful, but it must not be supposed it has anything to do with the oculist's or ophthalmic science; it is purely mechanical, but a very neat operation, which cures a very ugly deformity. I remember one case of cure on which I pride myself:—The daughter of a patient of mine married, and went to reside with her husband at Nottingham. She asked me to recommend her to a doctor, but I only knew one name, Mr. Higginbotham, who, whilst I was dressing for the late Sir William Lawrence at St. Bartholomew's Hospital, published in the *Lancet* his method of cure of inflamed glands by nitrate of silver. This lady bore a female child, which had ophthalmia neonatorum, and Mr. H. applied caustic pretty freely; so freely, indeed, that all the lace frocks were spoilt; but what was worse, the child became quite blind, and as soon as Mr. H. told the mother this, she started by the first train to the town where I resided, and came to her father's. Mild measures put the child perfectly well in three weeks, and there was not a speck on either cornea.

I will record one case of talipes to show that appearances are deceitful. One market day a Mr. and Mrs. W. from Lincolnshire, brought

their two daughters, both having club feet of the worst description. Fortunately they were young, one being ten and the other thirteen. After carefully examining them, I said I could cure them if Mrs. W. could remain with them and see my orders obeyed; she agreed to do so, but said she could not do so until the harvest was over, which would be in about seven weeks. I said very well; but in the meantime the children were not to be allowed to run about, but have their feet rubbed with oil and worked every day as I directed. This was agreed to, and they promised to come after harvest.

On their driving home this dialogue took place: "I'll tell thee what, my lad, if that man's the only one that can put our bairns' feet right, I think we'd better bring them soon, for he doesn't look as if he'd live six weeks." "Well, does thee know, I've been thinkin' so mysen, and we'll bring them back on Monday, and manage weet (*sic*) harvest the best way we can."

So on Monday, to my great surprise, Mrs. W. presented herself with the two daughters, and by way of apology she said, "You know, doctor, you said the sooner the operation was performed the better, so we thought we'd come at once and manage about the harvest without me." I said I was very glad, got them lodgings, and operated on the following day, which I had fixed to operate on a young lady at Pontefract. I operated on the three the following day, and—showing how painless is the operation—not one of them made the slightest exclamation. They were all cured; and then Mrs. W. ventured to tell me what had decided them to come before the harvest.

CATARACT PRODUCED BY NAPHTHALENE TAKEN INTERNALLY.

BARON SIR FERD. v. MUELLER, K.C.M.G., F.R.S., M.D., &c., Government botanist in Victoria, has favoured us with the following translation, abridged from a note in the Vienna *Zeitschrift des österreich. Apotheker Vereins* (1887), Vol. XLI., p. 38, relating to the above subject:—

"In the Paris Academy of Medicine, Professor Bouchard reported that animals to whom naphthalene was administered internally, got their lenses obscured within 20 days or less, without the cataract process being arrested by discontinuing the administration of the drug. Usually both eyes are affected simultaneously. The question, why naphthalene introduced by the digestive channels should produce cataract, has only as yet been theoretically answered, the idea being that the great affinity of that substance to sulphur chemically affects the globulin of the lens."

REPORTS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 61st General Meeting of the Branch was held in the Royal Society's Rooms, on Friday, 1st April. Present—The Hon. Dr. Creed (President), in the chair; Drs. Clark, Chambers, Graham, Maher, Hankins, O'Reilly, Brady, Quaife, Fisher, Clay, Clubbe, West, Lovell, Ellis, F. Ross, Roth, McCormick, Megginson, O. F. S. Evans, Hoff, Martin, Pockley, Sydney Jones, Jenkins, Scot Skirving (Hon. Secretary).

Visitors—Drs. Reddall, Carruthers, Paterson, and Moir.

The minutes of the previous meeting were read and confirmed.

The President announced the following new members:—Drs. O'Neill, Pockley, Coutie, and Finlay.

The Hon. Treasurer (Mr. HANKINS) read a letter from Mr. Fowke with reference to the election of a representative to the Council of the Home Association, and also one from Mr. Ernest Hart, editor of the *British Medical Journal*, relating to the publication of reports of meetings in that journal.

Dr. E. FAIRFAX Ross proposed, and Dr. MCCORMICK seconded, "That the Hon. Dr. Mackellar, M.L.C., be elected the representative of this Branch on the Council of the Home Association for the ensuing year."—Carried.

Dr. QUAIFFE read some notes on a "Case of Stomatitis, with Jaundice, &c." ; also Notes on a case of "Carbolic Acid Poisoning."

The cases were discussed by the President, Drs. Lovell, Clubbe, Hankins, Scot Skirving, and Evans.

FRIENDLY SOCIETIES.

Dr. CLUBBE moved the following resolution:—
"That this Association is of opinion that the present system of payment of Medical Officers by the various Friendly Societies is very unsatisfactory,"

and said: When I gave notice of the motion that stands in my name, I was told that it was a subject that had been discussed over and over again, and that it was worn threadbare, and that it was well-nigh useless to bring the subject up again. During the four years that I have been in this colony I cannot remember any discussion on this matter. We must remember that during the last few years there has been an immense quantity of new blood infused into the medical profession in Sydney. As the younger members of the profession are chiefly and so deeply interested in this matter, it is only right that an opportunity should be given them for expressing their views. At the outset I wish to disclaim any personal feeling in the matter. I have no lodges, nor am I ever likely to have any. This is a matter that affects the honor of the medical profession as a body, and anything that affects the profession as a whole, affects, or ought to affect, the individual member. I bring forward this matter in the interest of the profession at large.

I was anxious, in order that I might present this subject to you with some definiteness, to have obtained some statistics with reference to the various Friendly Societies in Sydney, but I regret to say that I am unable to do so. Although a yearly return is demanded by Government from every lodge, many of them fail

to comply, and as there is no special department set apart for this matter, the returns that are sent in are not tabulated, and practically nothing is done with them. Mr. Coghlan, the statistician, told me he thought that about 13 per cent. of the population of Sydney were in Friendly Societies. I fancy he calculated each member as a single individual, whereas those who have anything to do with lodges will know that such is not the case. Member may mean 6 or 9 persons, and the average number of persons for even so-called members is certainly 3 or 4. If this is true, we may conclude that about 40 per cent. of the people in Sydney are in Benefit Societies.

Now you must remember that the people in these societies are not by any means the poorest class of people. The majority of them are thrifty, well-enough-to-do people. The skilled labourers, stonemasons, brick-layers, plumbers, painters, &c., men who can earn £3 or £4 a week, and there are many others who might have been in poor circumstances once, but who by their industry have got on and have raised themselves, and who must now be classed among the well-to-do.

Now I want to know why it is that we as a profession should give our services to these people on what I may call purely benevolent principles? Can you call attendance for a whole year on a man, a woman, and half-a-dozen children, for the sum of 15s., anything else than eleemosynary? These people who haggle about an extra shilling a year in payment of their Lodge doctor, think nothing of putting £1 on some horse they fancy for a race. These men who do not pay their doctor 4 pence a week think nothing of spending 4 shillings a week in the public-house. And yet they entrust their lives and those of their wives and little ones to a man who is paid the magnificent sum of 3½d. a week! Mind you, I don't altogether blame the people. They would be fools indeed if they did not avail themselves of our generosity. Do you think if they advertised for tenders from lawyers for all their legal business to be done for them, that any, even the newest of the newly admitted, would tender at £1 per annum per member? No, lawyers are not quite such fools; they would laugh you to scorn if you suggested such a thing. Would any other trade or profession do it? Why then, I want to know, do we alone of all professions and trades exercise such great magnanimity and fling our wares, so to speak, at people, for a mere song, who despise us for doing so? We carry our stock in trade in our heads, it has cost us much time and money to accumulate, and yet we are so ready to part with it for nothing! As I said before, I do not altogether blame the members of the Friendly Societies. We are more to blame than they are. Unless we combine and make a stand, you will find that as medical men increase in numbers, that in the tendering for these lodge appointments the price will come lower and lower till it reaches zero; for this sort of thing is regulated by the law of supply and demand. If the supply exceeds the demand, unless there is some fixed rate, the price must go down. I have not the slightest doubt that many young men would rather have the lodge at nothing per member than not have it at all, simply and solely as a means of getting introduced to practice. I am not at all sure if it would not be a good plan if doctors were to offer to attend these people for nothing. We do it for next to nothing now—why not go "the whole hog"? I am sure I should infinitely prefer attending a lodge for nothing, rather than attend them for 7s. 6d. per member. It might possibly then dawn upon some of them that they were the recipients of charity, whereas they are now quite content to receive the services of their medical man and have no qualms of conscience however often they call him.

Are they not paying him the magnificent sum of 4*½*d. per week?

Very few of the doctors holding these appointments are satisfied with them. They hold them as a means to an end. The principle upon which they are worked is, I contend, utterly wrong. It is absurd to tender at any fixed sum per member for the year, seeing that it is quite impossible to foresee how much work will have to be performed. It is quite possible that 200 attendances may have to be given for 16s. It demoralizes the people. They are entitled to the doctor's services; they have paid their money. If they see him every day in the year they will not have to pay any more; so they rush at the doctor on the slightest pretext, when they would not dream of going to him if they had to pay every time. Is it to be wondered at that the lodge doctors are often surly and slur their work, when they are so frequently called on for such trivial ailments?

My idea is and always has been this, viz., that the way to get out of the difficulty is to do away for once and all with this tendering business at so much per member per annum. When a lodge calls for tenders let the doctor tender in this fashion:—Let him be paid by the amount of work he is called upon to do. Let him tender at so much per visit, and so much for advice at his own house. The doctor will keep an account of the number of visits, and number of times each patient comes to see him. At the end of the quarter he will send in his account to the secretary of the lodge. The lodge will pay the doctor, and the secretary of the lodge will recover from the member. In this way very many of the difficulties will be overcome. Doctors will go more cheerfully about their work. They will know that for every visit they pay, and every patient they see, they are earning something. The people will not be so eager to rush to the doctor for nothing, for they will feel that for every attendance they will have to pay something, let it be ever so small.

As many of you are aware, in order to get as much information on this subject as possible, I issued a circular to all doctors supposed to be holding lodge appointments in and round Sydney.

In this circular various questions were asked—No. of lodge? No. of members in each lodge? Average No. of people for each so-called member? Rate of payment? What proportion of lodge patients are in a position to pay? and lastly, Are you satisfied with existing arrangements?

I sent out about 100, and as rather less than half have replied, the information is not so valuable as it might have been. But this circular has been the means of getting a great deal of information and many valuable suggestions.

I find that the rate of payment per member per annum varies from £1 4s. to 7s. 6d., the average is about 16s. In some few instances the payment is £1 7s., but then medicines have to be supplied.

The Odd Fellows are 3000 strong, they have 4 medical men, and they pay £150 per annum each.

I find very few men keep any record of the number of attendances on lodge patients, so I have only been able to calculate the amount received for each attendance in a few instances. The amounts I got out were these:—6s., 3s. 6d., 2s. 8d., 2s. 5*½*d., 2s., 1s. 6*½*d., 1s. 4d., 1s. 2*½*d., 1s., 7*½*d.

It is very evident that a large proportion of lodge patients could pay at the ordinary rate, though the answers as to the exact percentage vary considerably, nearly every one thinks a certain proportion could pay. Some say "all," some 90 per cent., several 75 per cent., 50 per cent., 30 per cent., and the lowest 5 per cent.

The suggestions I received were very numerous, and

some at considerable length. Nearly all are agreed that something ought to be done, and nearly all agree that we should *unite* in self-defence, but many seem to fear that union is impossible. Nearly all think that the fees should be raised. Some few are quite satisfied with existing arrangements, if medical men could only be persuaded not to undersell one another. Many condemn in strong terms the touting for lodges that goes on to a considerable extent whenever there is one vacant. Many think the really well-to-do people should be excluded from benefit.

Since I have taken up this question I must confess that I am not over sanguine as to the result. The very fact of such a large number of men not taking the trouble to reply to the circular shows that they are indifferent about the matter and are presumably satisfied with the existing arrangements.

Now if anything is to be done to alter the present disgraceful state of affairs, it is quite evident that we must *unite*. If any large body of medical men refuse to do this, it seems to me to be utterly useless to attempt to do anything. If we can only act together we can dictate our own terms. As one gentleman says, "together we stand, but divided we fall." At present we seem to be a heterogeneous mixture. Oh, why can't we form ourselves into a homogeneous mass. If any gentleman this evening can suggest any method of bringing about this much-to-be-desired result, we may consider the battle half won.

Ours is justly considered a noble profession. We are all nearly daily brought into contact with cases where we freely and cheerfully give our time and talents without any wish or hope of reward. Thus it has ever been, and thus may it ever be. But while giving place to no man in my desire to see our help freely extended to the really deserving sick poor, I do object most strongly to this wholesale scattering of medical advice for next to nothing among people who do not need, deserve or appreciate it.

Dr. ELLIS said that he intended to move an amendment to Dr. Clubbe's resolution, as he (Dr. Ellis) thought it would be better to have some gentlemen on the committee who were not members of this Branch, say, one or two to represent the Medical Section of the Royal Society, and one or two gentlemen not connected with either society. In this matter the one essential thing wanted was union, and to have this the committee must be thoroughly representative.

Mr. HANKINS said he did not think a matter of this kind could be brought before the Medical Section of the Royal Society.

Dr. O'REILLY said that one of the suggestions thrown out by Dr. Clubbe had been tried and failed. Some years ago the medical gentlemen joined together for the purpose of keeping the rates of attendance on lodges up to something like a decent figure; but after a while several gentlemen expressed a wish to withdraw, and so the whole arrangement fell to the ground. At that time the lowest rate was 16s. per member per year.

Dr. MARTIN said that he had a good many lodges, but was certainly not at all satisfied with the rate of remuneration; besides which tenders were becoming lower and lower every day.

Dr. QUAYLE maintained that the whole system of tendering was wrong, and the treatment the medical man received at the hands of his lodge patient was simply scandalous.

Mr. HANKINS said he did not quite see how this combination could be brought about, as there was sure to be some who would hold aloof from any such arrangement. He (Mr. Hankins) thought that now the

subject had been reopened members would take the matter to heart, and so improve the tone of the profession generally.

Drs. MEGGINSON, PATERSON, CARRUTHERS, and SCOT SKIRVING also entered into the discussion.

The resolution was carried.

Dr. CLUBBE proposed, and Dr. QUAIFE seconded—“That the following gentlemen form a committee, Drs. Knaggs, Scot Skirving, Ellis, Hankins, and the mover, with power to add to their number, to inquire into the subject and to formulate some scheme of reform.”

Dr. ELLIS moved as an addition—“That this meeting authorises the committee to add to their number gentlemen who are not members of this Branch.”

Dr. CLUBBE accepted the addition, and the resolution as amended was carried.

Dr. LOVELL moved, and Dr. SCOT SKIRVING seconded—“That at future meetings the press shall be requested not to give particulars of any professional papers except by the invitation of the President.” Carried.

Dr. QUAIFE moved, and Mr. HANKINS seconded—“That the resolutions passed by the Branch on 6th August, 1886, relative to the subscriptions and *British Medical Journal*, be now rescinded.” Carried.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY MEETING,

Held at the Adelaide Hospital, January 27th, 1887, the President (Dr. Verco) in the chair.

BALLOT.—J. H. S. Finniss, M.B., was elected a member of the British Medical Association and of its South Australian Branch.

EXHIBITS.—Dr. Lendon exhibited a girl, age 3 years, upon whom he had operated for strumous disease of toe and ankle, following after injury to foot. The astragalus was removed and the adjacent articular surfaces of the tibia and fibula, and a spot on the os calcis were scraped. The result was a serviceable foot, with a little movement at the ankle joint.

Also a case of talipes varus in a malformed foot. The left foot has only three toes, is an inch and a-half shorter than the right one. The whole left lower limb was shorter and smaller. Tarsotomy was performed. The highest temperature any time after the operation was 100° Fahr. The result was that the child could stand on the sole of the foot. A cast of the deformity was shown.

Dr. Way sent a girl, aged 11 years, who was born cretinoid. The patient was the size of a three-year-old child. Can talk and tell her name. Features heavy and tumid. Tongue large, with hanging lower lip. Backward in her second dentition, namely, 1 incisor and 2 molars in the lower jaw, and 2 bicuspids and 2 molars in the upper jaw. The thyroid gland seemed small. Skin dry and harsh. Heart sounds normal. No albuminuria.

PATHOLOGICAL SPECIMEN.—Dr. Mitchell showed a cancer of the stomach, and gave the following particulars:—

“Two years ago Mr. R. McK., aged about 65, showed well-marked symptoms of cancer of stomach, with severe pain and vomiting of food, mucus, and blood, which resisted all treatment for several months. Then the symptoms cleared up and he suffered no more pain nor vomiting. Two months ago he found rapidly increasing difficulty in passage of faeces, and at last, two weeks before death, could not pass anything at all.

Purgatives produced no effect, enemas returned immediately. An India-rubber tube could not be passed further than the sigmoid flexure, but drew a small quantity of faecal matter from that point. Towards the end the abdomen became fearfully distended, and gas was drawn off by aspirator.

P.M.—Stomach was found invaded for three-fourths of its extent by cancerous growth, which greatly thickened the walls and lessened the cavity, so that it would hold barely half-a-pint of fluid. The posterior aspect was most affected, and the greater curvature was welded to the pancreas and the extreme left end of the transverse colon, seriously puckering this part of the bowel. The growth was pale and shaggy on its inner surface, and contained but few large bloodvessels.

At the sigmoid flexure of the bowel there was a well-marked stricture, caused by the puckering of the wall into an almost solid mass. This was upon the inner (or right) aspect of the gut, and was on the outer surface rather than in the lining. The constriction was so tight, that not even a very small wooden lead pencil would pass through it—say a No. 5 English catheter.”

Dr. Symons then read a paper on “Purulent Ophthalmia in Newly-born Children,” which will be published in our next issue.

The personal experience of the members present did not seem to point to any large number of cases as occurring in their individual practices. Dr. Symons was requested to obtain, as far as possible, some statistics from the cases that came under his notice of the proportion that were the result of this early form of ophthalmia. The question might then be considered as to the desirableness of petitioning the Central Board of Health to issue special instructions to nurses and others.

MONTHLY MEETING,

Held at Adelaide Hospital, February 24th, 1887, the President (Dr. Verco) in the chair.

Dr. Gardner exhibited his case of excision of the larynx (shown before); also a man on whom nephrolithotomy had been successfully performed; two cases of resection of both bones of the forearm for ununited fracture; a case of Spence's amputation of the arm in a male adult; a case in which there had been formation of new bone after removal of depressed comminuted fragments from fracture of the skull in a boy.

Dr. Giles showed a case of syphilitic ulceration of the thumb in a male adult, following a wound inflicted by the bite of a man reputed to be suffering from syphilis.

Dr. J. Davies Thomas read some notes on a case of peduncular tumour of the naso-pharynx, and exhibited the specimen. (*Vide* page 164.)

Dr. Hayward read a paper on suicidal mania in pregnancy, which will be published in the next issue of the *Gazette*.

The President, Drs. Giles and Gardner spoke to the paper, Dr. Giles mentioning a case of suicide in a pregnant woman who had been melancholic for some time.

Dr. Symons read notes giving the number of cases of ophthalmia neonatorum which had come under his observation, five in number, since the last monthly meeting, as a further instance of the necessity for some concerted action in the matter.

Dr. Symons laid on the table cases corroborative of the paper read by him at last meeting on ophthalmia neonatorum—showing that five new cases had come under his observation during the month. Of these, seven eyes had been lost before treatment, but three coming under early treatment were saved.

MEDICAL SOCIETY OF QUEENSLAND.

THE usual monthly meeting of the above Society was held in the School of Arts, Brisbane, on March 8th last.

There were present:—Drs. Bancroft, Campbell, Shout, Tilston, Little, Hare, Hill, McNeely, Gibson, Lyons and Love. Dr. Thorpe of the H.M.S. "Paluma" was present as visitor.

After the minutes of the previous meeting had been read and confirmed, the President showed a lively specimen of a scrub-leepch, and gave some interesting particulars as to its habits.

Dr. LOVE inquired if any of the members present had noticed a remarkable prevalence of skin eruptions, chiefly herpetic and eczematous, during the recent wet weather, and he also asked what was understood by local medical men by the term "native pox."

Dr. GIBSON had noticed a large number of such cases as Dr. Love had described, and he ascribed them to the insufficient evaporation from the surface of the body consequent upon the humidity of the atmosphere. Everyone had noticed how oppressive the weather had been. The skin secretions had been very active, and the ducts and follicles had become blocked with inflammatory results.

Dr. TILSTON thought the term "native pox" a very arbitrary and purely popular name for any of the eruptions of childhood.

DISCUSSION ON TYPHOID FEVER.

At the previous meeting of the Society Dr. HARE had read a paper on Typhoid Fever (which will be found elsewhere in our columns). After Dr. Hare had concluded his paper,

Dr. W. S. BYRNE thanked him for the great care and trouble he had taken, as he himself knew the labor of collecting statistics. He thought the question of stimulants rather omitted—he avoided stimulants as much as possible—he considered a dry, brown tongue demanded stimulants. He found pneumonia the great complication in Sydney at the Prince Alfred Hospital. For the pyrexia he liked cold bathing, but found it very hard to carry out in private practice.

Dr. TILSTON remarked that they had a good deal of typhoid in Roma. The water was certainly bad, but many to whom the water was supplied did not take it. He had his patients in the hospital sandwiched with the ordinary cases, and none of the latter ever took the disease. The laundress of the hospital contracted it, however, probably from soiled sheets. Occasionally they got a sporadic case by shepherds coming in with it from the bush.

Dr. THOMSON asked himself the important question—Are all these feverish cases typhoid? He believed they were all typhoid in a more or less modified form—the gastric fever one met in infants he believed to be a form of typhoid, but, unfortunately, *post mortems* were rarely obtainable. The question of contagion was a very difficult one to settle. He had seen instances of typhoid come in from the bush in men who had been in no contact with the disease. He had also seen typhoid in sailing vessels when coming to the Australian coast, though they had been free of it before. He had examined water from infected localities, by estimating the free ammonia and the albuminoid ammonia, but without any satisfactory result.

Dr. C. F. MARKS agreed with Dr. Thomson that these mild fevers, if not restrained by rest and diet, take on a typhoid character. He also thought that it was not contagious in the ordinary sense of the term. The Medical Society, he thought, should wake up the municipal authorities, make them provide covered

carts, and restrain the spread of the disease in every possible way.

It was then agreed that the discussion be postponed till the following meeting, and that the Council should draw up a series of questions which the members should be invited to pay special attention to in giving their personal experiences and opinions as to the disease.

In accordance with the resolution, the Council drew up the following questions, and forwarded a copy of them to all members.

1.—What relations do "Simple Continued Fever" and the so-called "Abortive Typhoid," bear to the typical Enteric fever?

2.—Is Typhoid fever contagious or infectious? If so, by what means and through what media?

3.—Can Typhoid fever arise *de novo*?

4.—Does one attack confer immunity?

5.—What is the influence of weather and season upon endemic Typhoid?

6.—What do you consider to be the nature and origin of relapses?

7.—What is your experience as to the frequency and diagnostic value of "rose-spot"?

8.—Treatment?

Dr. LITTLE, thought that simple continued fever and abortive typhoid were quite distinct in their characters; the simple continued fever generally starting more suddenly and developing more rapidly; the typhoid malady came on more gradually. If he had a mild case of fever with much languor, he would be suspicious as to its typhoid nature; if, on the other hand, the fever rose high and was accompanied with excitability, he would feel less apprehensive. However, he considered that all these feverish attacks about which there was any doubt should be regarded with caution, and practically treated as typhoid. There was no doubt that he had met cases of typhoid which aborted at the 8th or 10th day—cases which had all the typical symptoms, abdominal tenderness and tympanites, characteristic tongue, and rose-spots, and yet these had all come abruptly to a favourable conclusion at an early date. As to the question of propagation, he used to think that enteric fever was neither contagious nor infectious. Some years ago he was in charge of Maryborough Hospital for three years during bad fever seasons, and though he treated all his typhoid cases in the general wards, sandwiched with the ordinary cases, no secondary cases of fever occurred either among patients or nurses. However, he was now convinced that the disease was propagated from the stools, very often from some of the excreta which has been allowed to dry on sheets, linen, &c. He considered that, owing to the dry nature of the climate, and the high winds prevalent here, Brisbane was now thoroughly saturated with the typhoid poison, which had been spread in this fashion—the dried faeces being dessicated and actually carried about in the air: for instance, he found many cases occurring on the top of hills, when the position made bad drainage a physical impossibility. Occasionally, in families where 6, 7, or 8 took fever one after the other, he had been obliged to infer that the later were infected by the earlier cases, for had they arisen from the same general cause, he would have expected more simultaneous infection. With regard to the question as to whether typhoid could arise *de novo*, Dr. Little expressed himself as still unsatisfied—some cases were met with in the bush apparently away from all typhoid associations, and yet the germs might have been conveyed by the winds. He had practised for three years in Charters Towers, when there was not a single case of Typhoid fever—also he remembered the time when Townsville was ab-

solutely free—there was plenty of malaria, but no typhoid—and yet there was plenty of digging, &c., and turning up of new soil, but now the disease was rife in both places—no doubt introduced from other towns. He did not consider that one attack did confer immunity. As to influence of weather and season, of course statistics shew that the number of cases increase with the hot and diminish with the cold weather. After rains, when great heat followed, there were many cases. This year, in Brisbane, they had had such a long spell of wet weather that they had not had enough heat to judge—however, if the heat set in before the cold of the winter came on, they would see. As to rose-spots, he did not trouble much about them—but thought they were rather rarer here than in England, while sudamina were more common. As for treatment, it was such a vast question that he would merely touch upon the leading points. Rest, bodily and mental, was essential—often all that was necessary to cut short an attack. Twice before the late Dr. Power's fatal attack, he had had a short attack of fever, but by rest in bed and taking quinine he was able to cut them short. Dr. Little was sure on the first occasion that Dr. Power was sickening for typhoid, and the second time Dr. Moloney of Melbourne, who was on a visit, also thought that he was in the early stages of typhoid. On the third and fatal occasion, Dr. Power was travelling and could not obtain the necessary rest. In high temperatures, he found quinine was not satisfactory in two-thirds of the cases, merely affording a temporary reduction, besides giving rise to uncomfortable symptoms. For this purpose, the cold bath was undoubtedly the best—he even found his patients liked it, as a rule, better than the cold pack. In some cases, where nervous symptoms predominate, he had found small doses of opium very valuable, more as a stimulant than a sedative.

Dr. GIBSON thought that the fact of typhoid breaking out on railroads in course of formation was due, not to the turning up of the soil, but to its importation from elsewhere by one or more of the workmen. He thought the disease to be due to a specific germ, undoubtedly. It was hard to believe that burial, as mentioned by Dr. McNecly, did not kill these germs—but it might be so. The influence of weather upon the spread of the disease was very interesting. After damp weather, when great heat followed, fever was usually rife—for the germs multiplied actively in damp weather; but in very wet weather, such as they had been experiencing lately, the infecting matter might be washed away by the flow of water. After a moderate rainfall, however, followed by prolonged heat, the conditions would be most favorable for spread. He believed that there was no limit to the distance to which germs might be transmitted, especially as those of typhoid shewed great indestructibility. He had met with some cases in his practice which shewed in a very interesting way how the fever might spread from previous cases. In one instance, the father of a family had died from typhoid. One year after this a servant fell ill with the same fever; then four daughters—one of whom died in the hospital—all while living in the same house. Acting on his advice, the remainder moved to another house, in a healthier locality, and yet some months afterwards another child took the fever. In all these cases the fever had very much the same type, and all were grave cases. Then, the period which elapsed between the removal from the first house and the date of the fever, was too long for incubation, and he concluded that it had been caught from some infected clothing. He had examined the first house and could not note any marked sanitary defects. As for treatment, he had seen several instances of typical cases, which had aborted with rest

and proper diet. Medicines he did not think necessary, as a rule. For pyrexia, he was accustomed to use either the cold bath or sponging—in children, if above 103° ; in adults, if above 102° . In bathing his patients he thought it very important to put the head into the water—not the face, of course. If this precaution were observed, the temperature would always come down under 30 minutes, e.g., in one case he had brought it down from 108° to 100° . Moreover, he thought it more comfortable to the patient, and that possibly helped to control the temperature directly through the central nervous system. As for the irregular course of typhoid, they must thank the progress of the ulceration. He believed that in the later stages, the fever became almost pure septicaemia, and then he liked to give some antiseptic which would pass to the lower part of the bowel and act there, and in this capacity he had found salicylate of bismuth very useful. Its usefulness, probably, depending largely on its great insolubility allowing it to be carried to the lower part of the bowel.

Dr. CAMPBELL thought the origin of typhoid a most interesting question. He used to think that it originated *de novo*. When at Rockhampton hospital, he had had experience of an epidemic at Gracemere, when there had been fifteen cases in six weeks; it was put down to bad water, the people drinking the same water as the cattle, the excreta of the latter it was thought, having polluted the waterhole, the only one then in the neighbourhood. He referred to an excellent paper by Dr. Thomson, of Melbourne, who held that it did not originate *de novo*, but had been introduced into the colonies by a ship freighted with criminals. He, after some years of observation and inquiry, was of opinion that wherever the disease is found, it must have been introduced in some way or other. He did not think burial would suffice to kill the germs, they must be burned, or else they would be dormant and become active again when circumstances were favourable

Dr. BANCROFT said that when a bush settlement had grown into a village, there was no fever till some case was introduced, and then it spread right through it. He remembered a very instructive instance in his practice in a house in Brisbane, a servant girl had been engaged from an immigrant ship, where fever had been on board; soon after, one of the children of the house took fever and died. The family then went to a town 100 miles distant, for change; one child was sent to lodgings by itself, while the rest of the family took lodgings together, the latter took typhoid one after another, and the people of the house also took it, while the child who had been sent away remained free. Usually he found strict isolation of the patient, and disinfection of the excreta, sufficient to prevent the disease spreading in a household. Among his patients, a child in large family was supposed to have taken typhoid at school; the excreta were systematically disinfected and the child isolated, and he had ventured to predict that there would be no more cases in the house, but in three weeks to his surprise, another child sickened. On inquiry it was found that this little boy had slept in the same bedroom with the sick child; no other children suffered. Children and new chums, Dr. Bancroft thought, were specially susceptible to the disease, the latter particularly if living in boarding-houses. He thought that after every case of typhoid the proprietors should be obliged to have the room disinfected and cleaned. In private cases, he was accustomed to advise that the woodwork of the room in which a case had been nursed should be painted or varnished. He considered the stools to be the chief media of propagation, also milk and other food which had been standing exposed in houses where there was typhoid.

He considered that the disease should be treated more like scarlatina—with regard to prophylactic measures. Here, the warmth of the climate proved very favourable to the spread of disease. Compare the growth of plants, how it differed in different atmospheres; for instance, the Pepper tree grew in Brisbane to a height of 10 feet, in Toowoomba it was often 30 feet high; European peaches fruited in Toowoomba but not in Brisbane; Chinese peaches fruited on the coast but not up at Toowoomba. Similarly typhoid, which probably had its origin in a germ of vegetable nature, was modified here, and its spread favoured by climatic conditions. Dr. Bancroft thought that typhoid fever *might* arise *de novo*, but rarely. He did not consider that one attack conferred immunity, as he had seen two or even three in one patient. As to the influence of weather upon endemic typhoid, he remarked that, in warm moist weather with not much rain, fungi grew vigorously, with excess of rain, the common mushroom did not flourish, though the Jew's ear eaten by the Chinese grew well on dead logs in showery weather. In heavy rain typhoid seems to decrease; in dry weather spores of fungi become scattered by wind; typhoid seems then also to become more widely diffused. In droughts, too, the system became impoverished, as both vegetable and animal food were inferior, and so people were more liable to a severe form of the epidemic. As for rose-spots, he did not think them of any importance; moreover, they were often indistinguishably mixed up with spots of various kinds. With regard to treatment, he agreed that rest and quiet were essential; nervous patients occasionally required opium. He had had typhoid himself, and took chloral and morphia at times to procure sleep. Rice and milk he considered good food, but milk alone might be overdone. He did not like broth and beef-teas as they tender to windy dyspepsia. Rice and gravy would often be found to do good service, also bread and milk. Milk should always be boiled before use, as one did not know whence it came. He objected to cornflour and similar manufactured articles, as he was never certain of their constitution; arrowroot farina he thought was better. The motions should always be destroyed—if in the country it was easy to make a log fire and burn them. He disliked the use of carbolic acid as it disguised every other smell, and he did not know if proper cleanliness was observed. He found the best and most handy disinfectant was sulphate of iron—two pounds to the gallon of water. This could be put into beer bottles and used as occasion required. He would prefer to see excreta carried out of town by railways, and not allowed to enter the drains at all. In closets he liked sawdust better than earth, as being cleaner and more effective. Pine sawdust looked very cleanly. Eucalypt sawdust contained much tannin, which acted on the albuminoids of the evacuations. Very often the breath was fetid, and for this he found iodine mouth-washes useful—one drachm of the tincture to eight ounces of water. In cases with abdominal tenderness he liked leeching if the patient be a strong person—it was sometimes wonderful to see how the fever abated after a critical haemorrhage. He thought that too long fasting was injurious for the patient, and liked to have him taking something, so to keep the digestion going he used the bitter bark, Alstonia, as a tonic. He found butchers very subject to the disease, probably from their contact with meat which had been infected by flies. Flies, cockroaches, &c., were known to haunt closets, and it was quite probable that they carried the germs. Thorough cooking of animal food was necessary. Stimulants he liked in the later stages of the disease where strength was failing.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which is found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, APRIL 15, 1887.

EDITORIALS.

AUSTRALIAN SNAKES.

SOME correspondence of a particularly vague and inaccurate character has recently taken place with regard to these in the columns of the daily press in Sydney. Though the snakes themselves have been pretty accurately described and classified, from the naturalist's point of view, our knowledge as to the effect of the bite of the various venomous species is anything but satisfactory, and no branch of medical science displays a better opening for careful investigation by a competent man, with sufficient leisure, than the toxic effect of the bite of the various Australian reptiles. We use this word as, after the comparatively recent discovery of a lizard in Arizona whose bite is fatally venomous, the inquiry should not be confined to snakes merely. It is true that the late Mr. Krefft carried on some experiments in this direction, but they were not conducted with the needful strict accuracy. To obtain definite and final results, the weight of the snake and of the animal experimented upon should be noted, and the pulse and temperature of the latter carefully watched, both before and after the wound. The effects of the poison when conveyed directly by the bite of the snake and indirectly by injection with a hypodermic syringe after collection should be separately studied. We mention this as the experiments of Dr. Thompson, of Launceston, we are informed, show a marked difference in the effect, as the result of the two means. In Mr. Krefft's experiments none of these things were done. It is much to be regretted that every practitioner who has occasion to treat a case of snake-bite does not send either to us or to the local branch of the British Medical Association a report of the case, recorded as near the time of occurrence and with as much accuracy as is possible, giving the treatment adopted and the result.

We are of opinion that many of the most alarming symptoms present in every case of snake-poisoning are the effect of terror and not of snake poison, and this the Editor endeavoured to make manifest by a paper which he read before the N. S. Wales Branch of the British Medical Association and published in this journal of July, 1884.

The treatment adopted in many cases is, we think, terribly erroneous, and so far from tending to the patient's benefit, we believe, seriously perils his recovery. We consider the prevention of sleep and the reckless administration of alcohol, often of the vilest quality, amongst the most objectionable of the remedies we protest against. Nothing is more ludicrous than some of the descriptions given in the lay press of the treatment of cases of snake-bite, one, we remember, winding up with an expression of gratitude to the "town band" for its exertions in keeping the unhappy patient awake. In another, the described treatment is horrifying, consisting, as it did, principally in the administration of four bottles of brandy to a young girl in a very few hours. In this case we think her peril was due more to alcoholic than to snake poisoning.

THE DEATHS OF CAROLINE YATES AND JOSEPH SABATOWSKI.

SINCE our last issue a case of great public interest has occurred in Sydney, of which we will give an outline with such comments as we think are called for.

A young married woman named Caroline Yates, living apart from her husband, having become pregnant, and wishing abortion to be procured, applied to Dr. Sabatowski, a Pole, practising in Sydney, and claiming to possess the degree of doctor of medicine of Paris. After two or three interviews with him she became very dangerously ill, saying that he had performed an operation on her and injured her internally. She died on March 16. The police being informed of the occurrence an inquest was held, and the *post-mortem* examination disclosed extensive laceration of the uterus, evidently the result of the improper use of an instrument, death being consequent upon shock and peritonitis, caused by this injury. Dr. Sabatowski, on learning that an inquest was to be held, dis-

appeared, when a warrant was issued for his arrest. Nothing was heard of him until his dead body was found on Saturday, March 19th, in the bush at Hurstville, a suburb of Sydney, a *post-mortem* and subsequent analysis showing that he died from the effects of poisoning by cyanide of potassium, which had been self-administered.

This man, calling himself Dr. Sabatowski, had been practising in Sydney since August, 1885, about which time he presented a diploma of the University of Paris to the Medical Board for registration. As no applicant is required to give more proof of his identity with the person named in the diploma than his own declaration, he had no difficulty in obtaining compliance with his demand, though we believe considerable doubt was aroused as to his being really the true owner of the degree, for astonishment was expressed that a man so vulgar and apparently ignorant should possess the M.D. of so distinguished a school. For ourselves, after having made due inquiry, we think there is no doubt that he was not the person named in the diploma which he presented, but that he was an impostor sailing under the colours of another man. We cannot blame the members of the Medical Board for registering him, for they exercised all the precaution which the law enables them to do, and, however grave their suspicion, the man having complied with the law, they had no choice but to register him.

There are other well-known examples of the same fraud in New South Wales, but, though the men are well known, with the present state of the law, there is no remedy.

Sabatowski, ever since his first establishment, was notoriously a mere abortionist, and had but little, if any, legitimate practice. He was mixed up in a case of suspicious death some time before, but the inquest revealed nothing very definite. In that case the patient was a male, and there were strong suspicions that the death was the result of morphia poisoning.

HOW THE LATE PAUL BERT TESTED THE VALUE OF VACCINATION.—It is told of the late M. Paul Bert, as an instance of his scientific enthusiasm and fearlessness, that, at one time, when he was impressed with the prevalence of small-pox from which those vaccinated in youth, and not revaccinated, had suffered largely, he had decided to test for himself the value of revaccination; and he did so in a manner which might possibly have cost him his life had his doubts been justified. He was vaccinated, and afterward had himself inoculated at Havre with virus from a man who was dying of small-pox. He did not contract the disease.

THE GENERAL MEDICAL COUNCIL AND THE MEDICAL SCHOOL OF THE UNIVERSITY OF MELBOURNE.

A MEETING of the Council of the University of Melbourne was held on February 28, Dr. Brownless (Vice-Chancellor), in the chair.

The VICE-CHANCELLOR said that their business was to consider the letter prepared by the Faculty of Medicine in answer to a letter addressed to the General Medical Council by Mr. F. W. Elsner, F.R.C.S., of Richmond, pointing out the deficiencies of the curriculum and various other shortcomings in connection with the Medical School, such as the non-existence of clinical instruction, &c.

Dr. FETHERSTON said that the letter had not been circulated.

The VICE-CHANCELLOR said that Mr. Elsner wrote a letter, making certain charges against the Medical School, which were of a very damaging character. The Faculty of Medicine was asked to prepare a report replying to these charges, to be sent to the British Medical Council. The draft of that report or letter was now before them, but he thought it should be considered strictly private. There should be no possibility of Mr. Elsner, or anybody else, dealing with this communication until the British Medical Council had received it.

Dr. FETHERSTON moved that the letter be circulated, and marked "confidential."

This was agreed to.

[We hope that there is legitimate reason for the excessive caution shown by the Council of the Melbourne University in discussing this matter with such strict secrecy, and that its dread of publicity does not arise from the truth of the accusation made.—ED. A.M.G.]

THE IMMIGRATION OF PHTHISICAL PATIENTS IN RELATION TO DEATHS FROM PHTHISIS IN AUSTRALIA.

IT being well-known that many phthisical patients in the last stage of the disease are sent to Australia from Europe, and that the deaths of some of these swell the Australian records, Dr. H. T. Whittell, Registrar-General of Births and Deaths in South Australia, to ascertain how far this factor influences the returns, issued on 1st June last, instructions to the registrars in his colony to obtain, whenever possible, on registering a death from phthisis, information as to the length of time the deceased had resided in the colony. Since these instructions were issued 171 persons have died from phthisis, and it has been ascertained that 69 of these were born in the colony; 2 had been resident one year; 6, two years; 4, three years; 2, four years; 4, five years; 13 between five and ten years; 8 between ten and twenty years; 10 between twenty and thirty years; 24 between thirty and forty years; 1, forty-eight years. In 28 cases the length of residence could not be ascertained. Of those born in the colony, 9 were below twenty-one years old, and 38 between twenty and thirty years old. These observations require to be continued, but at present the immigration of phthisical patients is not shown to largely influence the number of deaths from this disease. We hope that the Governments of the other colonies will imitate the example set by the Registrar-General of South Australia, concerning a matter of such interest and importance.

[Contributed.]

THE PROPOSED MELBOURNE HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST.

A MOVEMENT is on foot in Melbourne for the establishment of a Hospital for Consumption, and several public meetings have been held, at which various resolutions were passed and promises of ample support received. The arguments in favor of such an institution have been exhaustively discussed and they may be briefly summed up thus:—

I. The Melbourne Hospital, which has always a large number of consumptive cases in its wards, is not suited for their treatment, and is obliged to dismiss them after a certain time, whether "cured" or only "relieved" as the returns state; the hospital further has in reality no room for these cases, as it is unable to accommodate even the most urgent cases, surgical or medical, under pressure such as is met with when a typhoid epidemic rages, and the extra burden is thrown upon the Alfred Hospital, which in the recent epidemic was filled up almost at the same time as the metropolitan institution, necessitating the erection by the Board of Health of a fever camp in its grounds, and this has been crowded since the day of its completion.

II. The sanitary condition of the Melbourne Hospital has of late been so indifferent that a great public outcry has been raised for its immediate removal, or destruction and re-erection; some of the staff condemned the institution in no measured terms, and Mr. Fitzgerald has refused to operate until a better state of affairs has been brought about. Up to date, however, nothing has been done, and the promoters of the Consumptive Hospital have seized upon the right moment for setting their movement on foot, since, argue they, if nothing is done for the improvement of the hospital, we feel it our duty to improve the condition of the unfortunate phthisical patients who either cannot gain admission to the hospital under the present conditions or prefer to die in their own homes to running the risk of what they are led to believe would mean instant death within the walls of the Melbourne Hospital.

III. In no city of equal size throughout the civilized world is there less provision made for the sick than in Melbourne, since two general hospitals and a homeopathic institution have to do the whole of the medical, surgical, and fever work;

of course the condition of the population is better than in any other city of the same size—hence, it is argued, there is no necessity for so many charities, as most people can pay for medical attendance at their own homes. But when we come to consider cases of phthisis alone, we must take in a number of important points, for instance, that a great number of cases are introduced into the colony from all parts of the world, on account of the supposed good effect of the Melbourne climate, some of the patients being well-to-do, others being destitute, and all strangers. Provision of some kind must be made for these, unless we impose a prohibitive poll-tax on all consumptive immigrants, or turn them back from our inhospitable shores. Some of these patients could pay for their maintenance, others would have to live on the charity ; at present they drift about in all directions until they die miserably in some stranger's house or at the general hospitals, if they have succeeded in gaining admission without recommendation.

IV. The number of phthisical cases in Victoria increases year by year ; under appropriate climatic and hygienic treatment those cases of non-tubercular character would have the best chance of recovery, whilst if left in a general hospital for a time and then discharged " relieved," they would only return again and again and ultimately die. A special hospital would reduce the death-rate considerably.

V. Special treatment of all phthisical cases is absolutely necessary ; in the wards of a general hospital this is impossible under existing circumstances, and at the present state of our knowledge it is as necessary to provide for the separation of cases of consumption as it is to isolate lepers, which is done in Victoria. To talk of "boarding-out" such cases, or of sending them to an Incurable Hospital, is similar to talking of allowing small-pox patients the run of the country.

VI. Melbourne is wealthy enough to endow and support an Hospital for Consumption (exception has been taken to this title, but it is in use at most similar institutions in the United Kingdom), and, if necessary, to build another general hospital. Dublin, whose population is less by 100,000 than that of Melbourne, and which is perhaps the poorest city in the world at present, has no less than 38 charities, including some 10 general hospitals second to none in the world, and all of these are supported by voluntary contributions, with the exception of the House of Industry, which gets a small Government Grant, and the Workhouse Hospitals.

And now for a few arguments which have not been generally advanced in favour of this institution from a medical point of view. The cases of

consumption require to be divided into two great classes, the non-tubercular or curable, and the tubercular or incurable ; at present this is not done anywhere, since the task of examining all sputa for the diagnostic bacillus is firstly too much for the overworked resident medical officers of general hospitals, and secondly, it would require a special knowledge of pathological histology which is not required by every licensing body's curriculum, and is seldom met with by accident in medical students, by whom the work would inevitably have to be done. A staff of honorary medical attendants conversant with the recent pathology and pathological histology of phthisis could soon get together a class which they would educate and train according to the most recent investigations, which done, there would be no difficulty in getting a sufficiency of hands to elaborate diagnoses for all future time, and what is at present but a very desperate-looking venture in surgery, namely, the removal of consolidated portions of the lung by operation, and drainage of suppurating cavities by resection of the ribs would in a special hospital become as ordinary a method of rational treatment as ovariotomy is in its own place. In a paper on "Tubercle, Contagion and Heredity," in last year's issue of this journal, I drew attention to numerous points in regard to the treatment at special institutions of phthisis in its two forms, and showed what kind of cases would benefit most by admission thereto, so I may be pardoned for referring to that paper in connection herewith.

As to locality for a site there can surely be no doubt as to the best situation for the proposed hospital ; to my mind Sorrento seems to be specially favored for the purpose, and resembles Ventnor in more than one particular, whilst the everlasting Australian sunshine will be added to a host of advantages hardly to be obtained anywhere else in the whole world. The distance need be no bar to the best medical advice being obtainable, for the trip can be made in a few hours down the bay, and it would not be necessary for the consulting staff to visit the hospital more than twice a week, since the treatment once laid down can be entirely carried out by an efficient resident staff, whose emoluments would of course have to be on a liberal scale. More might be said, but it will hardly be necessary, as a humane body of men has taken up this matter with determination, and will as surely carry it to its completion as was the Alfied Hospital, in spite of systematic and violent opposition, both lay and medical.

F. W. ELSNER, F.R.C.S.I.

Richmond, Melbourne, March, 1887.

LETTERS TO THE EDITOR.

SMALL-POX AT PORT DARWIN.

(To the Editor of the A. M. Gazette.)

SIR,—As you are, doubtless, aware, we have recently had a case of small-pox at Port Darwin.

Being the first case of a contagious nature, our system of quarantine was necessarily put upon its trial, and as we have the whole question of quarantine so prominently before us at the present time, I should like to invite a few comments in a medical paper.

I would first state that beyond setting apart a distant island in the harbour for the reception of cases of infectious disease, our precautions were practically nil.

When, therefore, a case of small-pox did arrive, all arrangements had to be made on the spur of the moment, causing, of course, much delay and some few hitches.

On Jan. 20th, the S.S. "Chingtu" arrived from Hongkong, having on board some 250 souls, of whom about 160 were Chinese coolies—30 for this port.

The ship was boarded by Dr. Wood, the Health Officer, after he had received satisfactory replies from the master to the usual questions. The Harbour Master and an official of the Customs also proceeded on board.

The Chinese passengers were in charge of a Chinese "doctor," but there was no European medical man on board, and Dr. Wood therefore mustered everyone for inspection. When he had all but finished, he discovered an undoubted case of variola in a Chinese passenger, the eruption being at apparently the third day.

Dr. Wood at once ordered the patient to be isolated in a boat towing astern, the passengers, their clothes, and the ship to be thoroughly disinfected, and came on shore again. He changed his clothes, underwent fumigation, and awaited instructions from Adelaide. Next day he was unfortunately totally incapacitated from work by illness, and I, a resident of only a few weeks' standing, being the only other medical man in the place, had to do the best I could in assisting the authorities. Being in total ignorance as yet as to what arrangements were to be made, it seemed to be my plain duty as a medical man to proceed on board the steamer and again examine the crew for further cases.

As my conduct has been adversely criticised, I may perhaps be allowed to make an explanation. Seeing that the master of the ship had already failed to discover the case, might he not again do so? or could he be blamed for failing to discover a case say in an initial stage of prodromal

exanthem? especially as skin eruptions of all kinds are very common among the lower classes of Chinese. (In the case in point there was a well-marked exanthem on the lower part of the abdomen).

Surely the presence of a medical man was necessary here. Suppose the ship had proceeded to sea with an undiscovered case of variola on board, might we not have had a repetition of the "Preussen" affair?

Having examined the crew and found no further cases, I returned in the launch for orders; was met at the landing stage and ordered into quarantine, being subsequently engaged to attend the patient.

Up to this point I find that my action was exactly that recommended by Dr. McLaurin, President of the Sydney Board of Health, and acted upon in the "Preussen" case (vide *Australasian Medical Gazette*, Jan. 15, 1887, p. 105), with of course the exception that I was acting without instructions, and had to return for them.

By this time instructions had arrived from Adelaide. Dr. Wood was ordered to isolate himself as much as possible, while everybody who had been on board the infected ship was ordered into quarantine. By the latter order the Harbour Master and Customs Officer, who had boarded the "Chingtu" with Dr. Wood and had come on shore again with him, were included. Whether they had acted rightly or wrongly I do not wish to discuss here, but seeing that the mischief (if any) was already done, I cannot but think that it was an unnecessary hardship and expense, partaking also of the ludicrous, to solemnly chase them off the shore, place them on a hired vessel, and tow them off to distant waters, where they were kept for 24 days, 21 being considered necessary for safety, and the extra 3 being added owing to the non-arrival of the order for their release from Adelaide. I was, at my own request, anchored off the island in a small craft—the only one obtainable—with an attendant, the patient and another attendant being located in tents on the island itself. The case was a simple one of variola discreta, and did favourably.

We were not released until 6 weeks had elapsed, 21 days after the last scab came away. I am happy to state that no further case has occurred either in our own community or on board the "Chingtu."

Such is a brief narrative of the facts, but there are a few points of local and general interest on which I should like a medical opinion:—

I. Was not the Health Officer right, as the only medical man in the place of official standing, in coming off again to the shore, knowing that on him principally (this being the first case of the

kind) must fall the burden of making all arrangements under orders of the authorities in Adelaide?

II. Is it not absolutely necessary that our port—the first of call for nearly all ships arriving from the north—should have some proper system of quarantine? As I have before stated, we have no provision except an island, which appears to me to have nothing to recommend it save its distance, being destitute of a proper water supply, unapproachable at low tide, small, low-lying, and consisting almost entirely of dense bush, the home of alligators, mosquitos, and malaria.

III. What are the reasons for considering a period of 21 days as necessary for detention, after the last patient has been declared well? I believe the incubation period of small-pox is placed at 14 days. I find in an article on the subject in Quain's Dictionary of Medicine, that Dr. Alex. Collie states "the patient may be discharged safely when the crusts and scales have disappeared, and not less than six baths have been given at intervals of two days."

IV. Ought not every large passenger steamer be compelled to carry a European doctor? As things at present stand, the Health Officer here, supposing he receives satisfactory answers to the usual questions, at once boards the ship and, with a view to making certain, inspects the whole of the crew and passengers. Should he discover anything of an infectious nature, he is at once quarantined by law. He is therefore liable about twice a week in this port to a period of detention of some six weeks, which in the case of a busy medical man is, to say the least of it, extremely inconvenient.

V. Ought not the Health Officer here to have more local power? At present all arrangements are made at Adelaide, 2000 miles away!

The startling and adverse criticisms made in the Adelaide papers, inspired, no doubt, by a somewhat mischievous telegram from a resident here, describing an extraordinary state of indignation in the town (a statement, by the way, which I have been unable to verify) do not, I think, concern us as medical men. I cannot but think, however, that they are calculated to do much harm, by fostering a feeling of scare, which is much to be deprecated in an outbreak of epidemic disease. The statement in a Sydney paper that our small-pox case was really one of chicken-pox is an interesting instance of distant diagnosis.

I am, Sir,

Yours obediently,

CHARLES LETHBRIDGE STOW,
M.R.C.S., L.R.C.P. Ed.

Palmerston, Port Darwin, N.T.,

March 15, 1887.

[No. 1.—Yes, if he took proper precautions for the disinfection of himself and clothes on landing.

No. 2.—Yes.

No. 3.—Though in the majority of cases the period of incubation of small-pox is about 14 days, yet cases have occurred in which this period has been prolonged, it is therefore only justifiable caution to make the period of detention 21 days after the last exposure to contagion.

No. 4.—We are of opinion that it is most advisable that all ships having a large number of souls on board should carry a doctor who has been properly educated according to the European system of medicine, but how this is to be enforced we can hardly say, except by fining every master whose ship arrives without evidence of his having shipped such an officer. Our correspondent must not overlook the fact that in Japan the practice of medicine is that of Europe, taught on the most approved principles, and that all medical practitioners there have to pass strict and sufficient examination.

No. 5.—We are of opinion that the Health Officer should receive good general instructions as to his course of duty and have absolute power to carry them out, being, of course, held responsible that he does not abuse such power. A Health Officer who is unfit to be entrusted with it is unfit for his post. The possession of this power is the more necessary at a place so distant from head-quarters as Palmerston, for circumstances might occur which would render communication with the central Government impossible for many days.—ED. A.M.G.]

ANTICS OF CORONERS.

To the Editor Medical Gazette, Sydney.

SIR,—My attention has been called to an editorial in your paper of the 15th ult. referring to certain inquests, and amongst them that upon one Charles Whittington at which I officiated, and the purport of which is a tissue of untruths.

So far as the injuries the deceased received when he came to me, they consisted of a compound dislocation of the middle finger of the left hand, and a superficial flesh wound of the arm, caused through a pitchfork having scored it in the fall. The former I reduced, and in the latter put one stitch. I asked the man whether he had sustained any injuries to the ribs, and he said "No, I am all right there, except the old hurts (referring to some old breakages), I fell on my hands and face on some soft litter. I ought to know what broken ribs are; let me put on my coat and go home." This was on the 22nd December last.

On the 26th December deceased called on me, having walked into town a distance of three or four miles. He stated he was first-rate, and showed me his finger, which was doing as well as could be expected. So far in reply to attending the man a week without finding out his ribs were broken.

Now the man with whom the deceased lived and for whom he was working came to me subsequent to the inquest, and stated that the deceased had, to shew his ribs were all right, gone through the "extension" motions (having been an old soldier), and further, on the Sunday and Monday before his death had been visiting his friends on foot, having walked several miles. On the Tuesday also he was turning a churn and carrying water with his uninjured hand, and on that night to shew how well he was, in going to the outhouse where he slept—to use the man's own words—"gambolled like a sheep, and said good night."

In the morning he was found by his employer lying on the edge of the stretcher, apparently as if he had been trying to get into it, in great pain and lock-jawed. When asked what had happened to him he could not tell, and said he did not know, and he died within the twenty-four hours. His employer's idea is, that during the night, in a fit or otherwise, he had attempted to leave the building, and in the dark had fallen over the sleeper (or step) to the ground a distance of about three feet.

It would appear miraculous if a man with five or six ribs broken and one perforating his lung could have acted for eight days as shewn above.

As regards my officiating at the inquest, as neither the broken finger nor the lacerated arm could have been the cause of death, I could see no impropriety in acting as I did. I might add that the man was without means, and was merely working for his maintenance, being an old man.

Your informant must be as conversant with the above facts as I am myself, and I can trace no other reason but malice for his action in so working through you.

I write you the above particulars without prejudice, and presume you will have the courtesy to publish them.

Yours obediently,

THOS. H. PROSSER,

Coroner.

Crookwell District, March 12, 1887.

[We hardly suppose that Mr. Prosser is intentionally so candid as to mean what he writes, viz., that the inquest held by him on the late Charles Whittington "is a tissue of untruths." As to the exciting cause of the "lock-jaw," it certainly was not a recent injury, and if, as is attempted to be shown by Mr. Prosser, the man's ribs were broken only on the night before his death, they were not responsible for it, though they may have been the origin if broken at the same time that his hand was injured, their fracture having remained undiscovered by Mr. Prosser, who treated him. On the whole we think the most likely cause of the tetanic seizure to have been the compound dislocation of the finger. All the papers in the case having been ordered to be laid before Parliament, we shall have the opportunity of thoroughly inquiring into the whole case, when we will further comment on it.—ED. A.M.G.]

MEDICAL ETIQUETTE.

(To the Editor *Australasian Medical Gazette*.)

SIR.—As your paper is our guide and "own familiar friend," will you kindly state the relations necessary to be observed between two medical practitioners in one town, (the only ones), one being coroner. You would oblige also if you would mention what work is get-able *re* the legal aspects of such a case.

Yours, &c.,

"INQUIRER."

March 4, 1887.

[WITHOUT full information of the particular grievances in dispute, we are unable to say more than each "should do as he would the other should do to him." Styrap's "Code of Medical Ethics" is the best work on the subject. For the legal aspect of the case our correspondent must study the Acts of Parliament dealing with such matters in this colony.—ED. A.M.G.]

ADDENDUM TO MY ARTICLE ON DRUMINE.

(*To the Editor of the A.M.G.*)

SIR,—There is an expression of reproach, frequently used, somewhat as follows: "Give him some of his own medicine." I should not complain of this regarding my alkaloid. About a month ago in alighting from a tramcar in motion I was dragged along the ground, and produced two brush-wounds, besides weakness at the knee-joint. Two days ago, in very damp weather, on getting up, the knee felt weak and I was almost a cripple. Pain increased, and about one p.m. there were marked tenderness and pain in the ligament from patella to tibial tuberosity, so that even rest in the recumbent posture gave no benefit. My stock of drumine (I have since found more of it) consisted of a particle or two on a filter paper; with this weak solution I performed subcutaneous injection in two or three places over the tendon, with the result that I could soon walk easily, and neither pain nor tenderness remained. Whether there was rheumatic or idiopathic tendonitis I will not say, but the result is evident, and if a so-called weak knee can be strengthened by drumine, and pain removed, there is surely a pretty evident case. I may be excused for referring to my first experiences. I had tried the drug on myself, and an old Scotchman with severe lumbago came to consult me. I told him I had a new drug, and that I had found other remedies fail. "Do what you think fit," he said. The result is known. I have never hesitated to use the remedy on myself, and I can conscientiously say that, from the benefit which I have derived from its use on my own person, I consider my labour very well spent in investigating its properties.

JOHN REID, M.D., M.A.

11 Spring-street, Melbourne.

THE INQUEST ON MARGARET SAMPSON.

(*To the Editor of the A.M.G.*)

SIR,—I am desirous of bringing the whole circumstances of the Breeza affair under the notice of the Medical Profession of Australasia through the medium of your valuable paper, especially since the public press has given a very unfair account of the case.

The facts of the case are these:—On Friday, the 4th March, 1887, I was informed that an unregistered practitioner, named R. B. Canney, had performed an operation on a woman, Margaret Sampson, at Breeza, which was followed by her death. On my way that day to the coroner, Mr. Patrick Brougham, I met Canney, who informed me that he had the night previously performed craniotomy, and used a common chisel. I orally informed the coroner of the affair, when he said he would telegraph to Breeza and to Sydney for instructions. On the following Monday, hearing that the body had been buried, I went again to the coroner when he said "I have heard nothing yet, and I think the matter will fall through." I told him I would not let such a case pass unnoticed, and so I took the train to Breeza that day and called on the mother and father of the deceased woman. They said deceased was in labor *only two* days, that she was not very bad and was able to walk about on the day of the operation; that late in the evening fits came on. They sent for R. B. Canney, thinking he was a doctor; he arrived at about 4 p.m., and operated that night at 8 o'clock. They said Canney did not tell them what he was going to do, that the screams of the girl during the operation

were so great that they had to leave the camp, and the father said that Canney was so covered with blood that he could not look at him, and that he and a neighbour saw Canney with a chisel which was covered with blood. Canney asked £10 10s. as his fee. On directions I went to a bush carpenter hard by, who showed me the following instruments lent to Canney, viz., two flat wood chisels, a large screw-driver, and a large pair of farrier's pincers. I was told also that the *only woman* present during the operation was a Mrs. Tighe.

These particulars I forwarded to the Minister for Justice, and added that Canney was an unregistered practitioner, and that there were three duly qualified Medical men within reach. On the 9th instant, the coroner called on me in a great hurry and requested me to make a post-mortem examination, wishing me to start at once.

The body was exhumed after 5 days burial, and on examination I found recent signs of childbirth. The uterus was completely torn from its attachment to the vagina and completely inverted, and lying wholly external to the body between the woman's thighs and resting on the floor of the coffin, the broad ligaments were still attached. The perineum was ruptured back to the sphincter ani and thence round the anus and into the ischio-rectal fossa. The external genitals were much torn; the bladder was empty and contracted; the heart normal; antero posterior diameter of pelvis $4\frac{1}{2}$ inches, transverse diam. $3\frac{1}{4}$. Deceased measured in height 5 ft. 6 inches, and was very broad-shouldered and appeared to be about 18 years of age.

The infant appeared to be full timed and well nourished, the two parietal bones and part of occipital had been removed, the brain matter was also gone. I wrote the particulars of this examination in my deposition, adding as the cause of death "*to be due to shock consequent on laceration and inversion of the uterus.*"

At the inquest R. B. Canney was first called, he took about two hours to make his deposition, and while he was giving his evidence I was not allowed to be present, and the coroner was so particular that I should not hear what was going on that he sent the sergeant of police out to turn me off the verandah. When I was called I simply read my depositions, not being asked any questions either by the coroner or sergeant. By a juror I was asked—is it possible for a child to be born alive after the mother has been four days in labor? I answered yes, especially in first cases, but I remarked, this woman by the parents' account was only two days in labor; and in answer to a question what should be done in case of convulsions, I was about to describe chloroforming when the coroner stopped me, saying "I want no lecture here." It took under 10 minutes to give my evidence. I may add that I am in total ignorance of what Canney said on oath. I was not asked one word as to whether he did right or wrong. Dr. Middleton being called, he confirmed some of my evidence and rejected other parts. The following questions were put to him:—Is it possible for a child to be born alive after the mother has been 4 days in labor? No. Do you think that anyone could have saved Margaret Sampson? No, not even the most skilled operator (mind he never saw the woman alive). Do you think R. B. Canney acted correctly? Yes; he did the right thing. It is what I should have done. What do you think death was due to? Exhaustion from protracted labor.

Then comes the coroner's summing up with not one word about Canney being unregistered. "You have heard, gentlemen of the jury, Mr. Canney's statement; he described to you what he did. He also showed you the proper instruments, and how to perform the operation properly; he said he had not his instruments with

him, but he did his best without them, and gentlemen of the jury, *it is your place to decide whether* you think R. B. Canney guilty of malpraxis; if you think he did not perform the operation properly, and the woman died from his treatment, you must convict him of manslaughter."

The finding of the jury I think is pretty well known, but I leave the matter for "the medical profession to decide as to the correctness of this finding."

I am, Sir, &c.,

E. J. A. HAYNES,
L.R.C.P. LOND., M.R.C.S. ENG.

Gunnedah, N.S.W., March, 1887.

[The depositions taken in this case will, we are informed, shortly be laid before Parliament. Until they are we defer our comments on it. We, however, may say that we think it would have been more satisfactory had the evidence been sent, on arrival in Sydney, to the Medical Adviser of the Government for his perusal and report.—ED. A.M.G.]

OBITUARY OF DR. MAHER AND CORRECTION.

(*To the Editor of the A. M. Gazette.*)

SIR,—In your last issues I noticed the obituary of Dr. C. H. Maher and the subsequent correction, and I very much regret that your informant did not give you more complete and trustworthy information for that correction. The real facts are that George Herbert Maher died on January 15, 1887, at his father's residence in Burwood, of Phthisis (not of Typhoid Fever as stated in both notices). As the obituary list in the *A.M.G.* includes only the names of members of our profession, and as the correction in your last issue does not allude to the fact that George H. Maher was virtually, although not actually by final examination and registration, "one of us," I am anxious that it should be made quite clear. George H. Maher had a very brilliant career at Trinity College, Dublin. He took his B.A. and LL.B., the latter with high honors, and had completed the courses necessary for taking his degree of M.B. when he was struck down by the disease to which he subsequently succumbed.

His talents were of a very high order, and his personal qualities, together with tastes of a highly cultivated nature, endeared him to all those with whom he came in contact. I, who had the privilege to attend him in his last illness, can best bear witness to the courage with which he fought against his disease, and those of us by whom he was surrounded know best what a brilliant future there was before him if he had been spared to practise his profession.

Apologising for trespassing upon your space,

I am,

Yours, etc.,

DAVID COLLINGWOOD.

Summer Hill (Sydney), 22nd March, 1887.

[We are pleased to insert Dr. Collingwood's letter, but must express our regret that, thinking Mr. George Herbert Maher "one of us," he did not see fit to send us timely and correct information for an obituary notice instead of leaving the matter to be dealt with on chance information.—ED. A.M.G.]

CREMATION.

IT is with natural satisfaction that we reprint the following extracts from a leading article in the *Lancet* of Feb. 19 last, the more so as we believe it to be the first occasion on which it has in any way given favourable countenance to the practice:—

"Cremation is rapidly making its way in some civilised communities. Sensational objection to it is subsiding, and the gentler part of the creation, to whom not long since it was most objectionable, has, so to speak, come round to it with such effect that at a meeting of the Ladies Somerville Club, held a year or two ago, with one of the representatives of medicine in the chair, a resolution in favour of cremation was carried by a large majority. For many and sufficiently valid reasons we have been most careful in these columns not to favour cremation until we could see how it might be carried out, *cito, tuto*, and like the Latin poet, have felt our anxiety, "*tuta timens*," to the extent of fearing safety. For this there was abundant cause in one danger alone—namely, that men inclined to commit murder might find in the crematorium the easiest concealment of their guilt. At the same time we never doubted the value of cremation as a sanitary measure, and now that some of the more serious difficulties surrounding it are passing away, we are open to all fair discussion of its progress. In New South Wales a Public Bill authorising cremation passed through the Legislative Council on August 6th for presentation to the Legislative Assembly. * * * * *

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We have presented the leading principles of the measure, and we are bound to admit that they are as sound as they are vigorous and effective. The provision which makes it impossible for anyone who has an interest or expectancy in a deceased person to obtain a "cremation permit" removes the one great objection, which we have always enforced, more efficiently than any other plan that has hitherto been proposed, and seeing that cremation is apparently already recognised by the law of England, we should be glad to see an Act passed in this country on the same lines; for it seems to be proved by recent cremations that there is no real obstacle to cremation in England in the present state of the law, and there was no real obstacle in New South Wales. But, with much common sense, our colonial brethren have preferred to proceed in this matter by virtue of an affirmative rather than a negative law, and they are unquestionably in accord with the spirit of the times in carrying out this principle. They have, in short, made the law on a great sanitary question intelligible and fresh, so that everyone can understand it and act upon it. We must not conclude this article without claiming for the profession of medicine in the Antipodes considerable credit for the part it has played in the matter of cremation legislation. To one of our medical *confrères* in Sydney, the Honorable John Mildred Creed, who, in a speech exceedingly able and exhaustive, moved the second reading of the bill in the Legislative Council of New South Wales, a tribute is due for the success which so far has been achieved towards bringing cremation into a legal and safe practice on the other side of the globe."

MR. BRUCK, of 35 Castlereagh-street, Sydney, has just received a supply of the new kind of Clinical Thermometers for the vest-pocket, in form and size of a lady's watch; the price of this novel thermometer is 35s.

THE MONTH.

NEW SOUTH WALES.

THE following examiners in medicine have been appointed by the Senate to act with the lecturers in conducting the third professional medical examination at the University of Sydney:—Medicine, C. M'Kay, Esq., M.D.; surgery, A. Renwick, Esq., B.A., M.D.; midwifery, C. K. Mackellar, Esq., M.B., C.M.; medical jurisprudence, H. N. M'Laurin, Esq., M.A., M.D.; psychological medicine, Sir Alfred Roberts, M.R.C.S.

AT the meeting of the Senate of the University of Sydney, held on March 21, a letter was received from Professor Dr. Stuart, urging the immediate appointment of a Tutor in Medicine. After some discussion upon the necessity of appointing such an officer, and also upon the question of the adequacy of the University finances to meet the additional expenditure proposed, Professor Stuart gave notice of the following motion:—"That steps be immediately taken to carry into effect the first of the recommendations of the Faculty of Medicine, by establishing a tutorship in clinical medicine, at a salary of £200 per annum."

DR. F. MILFORD has applied to the Board of Directors of the Prince Alfred Hospital, to be allowed a number of beds in the surgical wards, to enable him, as lecturer on the practice of surgery at the Sydney University, to illustrate his lectures by giving clinical instruction at the bedside to the students; the request was referred for the report of the medical board of the hospital.

IN the Legislative Assembly, on April 5, the Colonial Secretary, in reply to Mr. McElhone, stated that the salary paid to the late Dr. Alleyne, as health officer, was £600 per annum, and that the cost of his department during the three years (1880, 1881, and 1882) was £3,596 12s. 9d., including the cost of suppressing a small-pox epidemic. The present health-officer (Dr. MacLaurin) was paid £680 per annum, and was allowed private practice when not engaged in the duties of his office. In Sydney and suburbs there were two medical men employed as health officers, namely as assistant officer at Watson's Bay (Dr. J. C. Sibley), with a salary of £550 per annum, and an inspector of the Board of Health (Dr. Ashburton Thompson), with a salary of £550 per annum. In 1885 the cost of the Health Office was £8,103 4s., and in 1886, £6,674 0s. 8d., both of which years included the expense of suppressing small-pox.

THE seat of Dr. W. Camac Wilkinson, one of the members for the Glebe, was, on March 22, on the motion of Mr. M'Elhone, referred by the Legislative Assembly to the Elections and Qualifications Committee. Mr. M'Elhone moved that the committee inquire as to whether Dr. Wilkinson was not at the time of his election, as well as at the present time, disqualified from sitting and voting as a member of the Assembly by reason of his holding an office of profit under the Crown as a lecturer of the Sydney University, the salary for such office (£300) being paid out of the endowment fund voted by Parliament. After due enquiry, the Elections and Qualifications Committee decided that Dr. Wilkinson's position as lecturer at the Sydney University, does not disqualify him from sitting and voting as a member of the Legislative Assembly.

DR. H. N. MACLAURIN has been appointed Vice-Chancellor of the University of Sydney for the ensuing year.

A YOUNG woman, named Caroline Yates, acting as housekeeper for a pawnbroker in Redfern, near Sydney, died on March 16th under peculiar circumstances, which pointed to her having been the victim of malpractice. A *post-mortem* examination was made by Drs. Long and Milford, and they ascribed the cause of death to peritonitis and shock resulting from a dreadful injury to the womb, which had been done by some sharp instrument with the intention of procuring abortion. The operation had been performed by Dr. Sabatowski (M.D., Paris), of Paddington, who had disappeared from his home; a warrant was then issued for his arrest, but all efforts to trace him failed till March 19, when his body was discovered in the bush at Hurstville, 10 miles from Sydney, under circumstances pointing to his having committed suicide by poisoning; he was a native of Poland and 43 years of age, and had practised in Paddington since his arrival in the colony, in August 1885.

DR. ALEX. BARBER, formerly of Narrandera, has commenced practice at Mudgee.

DR. E. G. BLAXLAND, late Assistant Medical Officer at the Little Bay Coast Hospital, has been appointed one of the Resident Medical Officers at the Prince Alfred Hospital, Sydney.

DR. F. M. BROWN, late of Richmond, has settled at Cootamundra, the centre of an extensive agricultural and pastoral district, 253 miles S. of Sydney.

DR. JAS. BRUCE, late of Newtown, (Sydney), and formerly Resident Medical Officer at the Sydney Hospital, has succeeded to the practice of Dr. F. M. Brown at Richmond, on the Hawkesbury River, 38 miles N.W. of Sydney.

DR. T. J. HENRY, a native of the colony, has commenced practice at 253 Oxford-street, Paddington, (Sydney), the late residence of Drs. Clayworth and Paton.

DR. P. SYDNEY JONES, of Hyde Park, Sydney, has been elected Honorary Consulting Physician to the Prince Alfred Hospital.

DR. H. B. KIERNANDER, a recent arrival, has succeeded to the practice of Dr. G. P. Baldwin, at Murramburrah.

THE HON. DR. C. K. MACKELLAR, M.L.C., of Sydney, left on a visit to Europe by the R.M.S. "Valletta," on April 1st.

JOHN MORTON, L.R.C.S., Edin., L.S.A., Lond., 1850, formerly of Tenterfield, and late of Eden, died from apoplexy at Milton on April 3.

DR. R. T. PATON, late of 253 Oxford-street, Paddington, Sydney, has been appointed Resident Surgeon at the Public Works Prison, Trial Bay, near Kempsey, vice Dr. B. N. Casement, resigned.

DR. W. G. TAYLER, of Moss Vale, and Dr. R. B. Warren, of Wagga Wagga, have exchanged practices.

NEW ZEALAND.

DR. F. W. E. DAWSON, of Auckland, has been appointed a Member of the Medical Board, Auckland District, constituted under the Military Pensions Act, 1866," *vise* Goldsborough deceased.

DR. A. C. MILNE, a recent arrival from Aberdeen, has commenced practice at Masterton, in an agricultural district, 70 miles N.E. of Wellington.

THOMAS PEMBERTON, L. et L. Mid., R.C.P. et R.C.S. Edin., who arrived in Australia from South Africa about six months ago, has died at Wellington, from an overdose of morphia; the deceased gentleman leaves a wife and large family badly provided for.

QUEENSLAND.

A MOVEMENT is on foot to establish a Queensland University in Brisbane.

DR. WILTON W. R. LOVE, of Wickham Terrace, Brisbane, has been appointed Honorary Visiting Physician to the Lady Bowen Maternity Hospital.

DR. H. C. GARDE, of Maryborough, and Dr. W. A. Browne, of Bowen, have been appointed Surgeons in the Queensland Defence Force.

DR. W. J. TILLEY, a recent arrival from the old country, has commenced practice at Warwick, an agricultural township near the Southern border, 166 miles S.W. of Brisbane.

SOUTH AUSTRALIA.

DR. L. S. O'FLAHERTY, of Hindmarsh, has been appointed a Justice of the Peace.

TASMANIA.

A SANITARY conference of the Hobart and Launceston municipal councils opened in Launceston on March 16.

A NUMBER of medical men have signed a protest against the practice of pouring sewage matter into the river at Launceston. They consider that it has been the cause of many cases of typhoid fever.

JOHN MOORE MACNEECE, L.F.P.S. Glasg., 1854, Government Medical Officer, died at Deloraine last month; the deceased gentleman was formerly an Assistant Surgeon in the army.

DR. W. G. MADDOX has resigned his position of Surgeon to the Launceston Rifle Regiment.

VICTORIA.

THE Chief Secretary, Mr. Gillies, has written to the Premier of South Australia notifying him that the Victorian Government would co-operate with the other Federal Governments in the establishment of a federal quarantine station, as first proposed some years ago by the Hon. Dr. Mackellar, late President of the N. S. Wales Board of Health.

AT a meeting of the Committee of the Melbourne Hospital on March 8, on the proposal of Mr. T. J. Davey, seconded by Mr. G. Godfrey, a motion was carried that in future appointments to the Resident Medical staff (except the Medical Superintendent) shall be without salary.

AT a meeting of the Melbourne Hospital Committee, held on April 5, Mr. Plunkett gave notice that he would move that the resolution to discontinue the payment of £50 per annum to resident medical officers be rescinded.

AT a meeting of the Honorary Medical staff of the Alfred Hospital, on March 30, Dr. Embling was unanimously elected Chairman in lieu of the late Dr. Blair.

THE celebration of the commencement of the twenty-fifth session of the Medical School in connection with the University of Melbourne, took place on March 22.

THE three metropolitan Lunatic Asylums (Kew, Yarra Bend and Sunbury), are so greatly overcrowded that a number of patients have to sleep on the floor in the day rooms, and at the Yarra Bend Asylum in a gardener's cottage and the recreation room; to overcome this unsatisfactory state of affairs it is intended to board out a number of those patients who are not actually mad, but only imbecile.

THE total number of reported cases of typhoid fever from January 1 to March 24 is 1,043, of which 213 were fatal. It is believed that the number of cases reported do not represent the actual number by one-half.

MESSES. WALKER AND SON, biscuit manufacturers, of Melbourne, were proceeded against at the City Police Court on March 28, at the instance of the Central Board of Health, for using a poisonous green pigment, namely, arsenic and copper in certain biscuits manufactured by them. The action was taken in consequence of two children having recently suffered serious illness through eating some of their biscuits. The defendants were fined £20 and costs.

A HANDSOMELY illuminated address was presented, on March 17, to Dr. James Robertson, one of the honorary physicians of the Melbourne Hospital, who has retired from office prior to making a trip to the old country.

DR. EUGENE ANDERSON, late of Balranald (N.S.W.), is at present residing at "Marama," Carlisle-street West, St. Kilda, a fashionable suburb of Melbourne.

DR. F. D. BIRD, of Melbourne, has removed from Lonsdale-street to 188 Collins-street East.

DR. A. C. BROWNLESS, who has for 29 years occupied the position of Vice-Chancellor, has been elected Chancellor of the Melbourne University.

DR. J. M. BRENNAN, late of Milton (N.S.W.), has commenced practice at Corryong, 260 miles N.E. of Melbourne.

BRIGADIER-SURGEON DR. FULTON, of Melbourne, who left for Europe by the P. and O. R.M.S. "Valletta" on April 7, was entertained at dinner by a large number of staff-officers representing all branches of the service, at the Grand Hotel, on March 25.

DR. DAVID GRANT, Lecturer on *Materia Medica* at the University of Melbourne, has commenced practice at 161 Collins-street East, Melbourne.

DR. C. H. MOLLOY, one of the Resident Medical Officers of the Melbourne Hospital, who had been on leave of absence suffering from blood poisoning in the hand, has tendered his resignation as his hand was not better.

DR. A. H. PARKER, late of Mannum, S.A., has commenced practice at Post Office Chambers, corner of Bourke and Elizabeth streets, Melbourne.

DR. M. BARCLAY THOMSON, of South Yarra, delivered a lecture on nursing at the Alfred Hospital on Thursday, March 31, to the pupils in training, the nursing staff, and a number of lady visitors.

DR. HY. STOKER has settled at Wycheproof, Dr. E. Harkness at Maryborough, Dr. E. B. Robertson at Seymour, and Dr. G. M. Reid at Birregurra.

WESTERN AUSTRALIA.

DR. THOS. FRIZZELL, of Roebourne, has been appointed a Justice of the Peace.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Goodall, William Ainslie, M.D. & M.Ch. Victoria Univ., Toronto, 1885; L.K.Q.C.P. Irel., 1886; L.C.P.S. Ont., 1886.
Kierander, Herbert Byrne, L.R.C.P. Edin., 1880; L.R.C.S. Edin., 1876.
Korff, Berthold, Staats-examen. Certif., Munich, 1884.
Bradford, Robert Dickie, L.R.C.P. & R.C.S. Edin., 1882.
Semple, William Macphun, M.B., M.S. Glasg., 1886.
M'Donogh, Bernard, L.R.C.P. & R.C.S. Edin., 1886; L.F.P.S. Glasg., 1886.
Seabrook, Thomas Edward Fraser, M.D. St. Andrews, 1861; M.R.C.S. 1880.

For additional registration:

Westrum, Richard, M.D. Munich, 1886.
Wilkinson, William Camac, M.B. Lond., 1882; M.D. Lond., 1884; M.R.C.P. Lond., 1884.

NEW ZEALAND.

Jeffreys, James Graham, L.R.A. Lond., 1877.
Milne, Alexander Cumming, L.R.C.P. & R.C.S. Edin.; L.F.P.S. Glasg., 1886.

QUEENSLAND.

Mellish, Percy Henry Septimus.
Tilley, William James, L.R.C.P. Lond., 1884; M.R.C.S. Eng., 1884.

SOUTH AUSTRALIA.

Burkitt, Frederick William, L.R.C.P. Edin., 1878; L.F.P.S. Glasg., 1865; L.A.H. Dub., 1865.

VICTORIA.

McClure, William George, M.R.C.S. Eng., 1847; M.D. Glasg., 1847.
Parker, Alfred Henry, L. & L. Mid. R.C.P. Edin., 1870; L.S.A. Lond., 1870.
Stoker, Henry, L.R.C.S. Irel., 1884; L. & L. Mid. K.Q.C.P. Irel., 1885.
Brennan, John McDonald, L. & L. Mid. F.P.S. Glasg., 1868.
Harkness, Edward, L. & L. Mid. R.C.P. & R.C.S. Edin., 1886; L.F.P.S. Glasg., 1886.
Deck, Henry O'Brien, M.B. Melb., 1886.
Wardale, Joseph Augustus William, L.R.C.P. Lond., 1872; M.R.C.S. Eng., 1872.
Robertson, Edward Bruce, M.B. & Ch.M. Edin., 1872.
Reid, George Marr, M.B. & Ch.M. Aberd., 1886.

WESTERN AUSTRALIA.

Laffan, James Thomas, L.R.C.S. Irel., 1881; L. & L. Mid. K.Q.C.P. Irel., 1882.
Roberts, Frederick Joshua, L.R.C.S. Irel., 1877; L. & L. Mid., 1878, M., 1884, K.Q.C.P. Irel.

MEDICAL APPOINTMENTS.

Bird, Edwin Jeffrey, M.B. Melb., to be Health Officer and Public Vaccinator at Northcote, Vic., vice Dr. R. E. Weigall, resigned.
Burkitt, Frederick William, L.R.C.P. Edin.; L.F.P.S. Glasg., to be Public Vaccinator at Port Augusta, S.A.
Cumming, William, M.D. & Ch.M. Ed., to be Public Vaccinator at Lillimur North, and for the district of Kaniva, Vic., vice Dr. A. Steven, resigned.
Davies, Thomas Sydney, L.R.C.P. & R.C.S. Ed.; L.F.P.S. Glasg., to be Public Vaccinator for the district of Thoona, Vic.
Duigan, Charles Beamish, L.R.C.P. & R.C.S. Edin., to be Public Vaccinator at Richmond, Vic.
Finlay, Sinclair, L.R.C.S. Irel.; L.K.Q.C.P. Irel., to be Government Medical Officer and Vaccinator for the district of Port Stephens, N.S.W.
Gutteridge, Matthew Wilkins, M.B. & Ch.M. Ed.; M.R.C.S. Eng., to be Surgeon to the Lancashire Rifle Regiment, Tas.
Hawkins, William Robert, M.D. & Ch.M. Royal Univ. Irel., to be Government Medical Officer and Vaccinator for the district of Brewarrina, N.S.W.
Hewer, William Henry, M.R.C.S.E., to be Government Medical Officer on the Central Railway Line, Queensland.
James, Edwin Matthews, M.R.C.S.E., to be a member of the Medical Board of Victoria, vice Dr. Blair, deceased.
Rock, Denis, M.R.C.S.E., to be Government Medical Officer for the district of Deloraine, Tas.
Samson, Henry Augustus, M.B. & Ch.B. Melb., to be a Junior Deputy Medical Superintendent, Hospital for the Insane, Vic.
Swayne, Herbert Wigan, M.R.C.S.E., to be Government Medical Officer and Vaccinator for the district of Ballina, N.S.W.
Young, Richard Weekes, M.R.C.S. Eng., to be Assistant Medical Officer at the Little Bay Coast Hospital, near Sydney.

THE INSANE POPULATION OF NEW SOUTH WALES IN 1886.

ON December 31st, 1886, the number of registered insane persons in the colony was 2,717, viz.:—1,644 males, and 1,073 females. The number on the register at the close of 1885 was 2,643, so that the increase for the year, after calculating all the discharges, deaths, &c., was 74. This is the smallest increase in any year since 1876, but it must be borne in mind that the increase for the years 1884 and 1885 was exceptionally large, and the increase for the quinquennial period ending 31st December, 1886, was 499, or nearly 100 per annum. The estimated population of the colony at the close of the year was 1,030,762, so that the proportion of insane to population at that date was 1 in 379, or 2·63 per thousand, a proportion which is smaller than at the close of any year since 1870, and compares favorably with the proportion in England, which was 1 in 348, or 2·87 per thousand, at the close of 1885. During the year 541 persons were admitted for the first time, viz.:—345 males and 196 females; the readmissions numbered 26, and the total number under care during the year was 3,325, viz.:—1,989 males and 1,336 females. Of these, 273 recovered, 26 improved, 7 escaped and were not recaptured, and 187 died. The average number resident during the year was 2,639 (1,604 males and 1,035 females), or 104 more than the average for 1885. The percentage of deaths on average number resident is, for males, 7·54; for females, 6·37; for both sexes, 7·08. The previous year it was, for males, 7·61; for females, 4·97; for both sexes, 6·58. The number of patients discharged recovered was 273 (174 males and 99 females), and was the highest number yet discharged in any one year. It gives a percentage of 48·14 on the admissions and readmissions, which is higher than the percentage during the past ten years.

The receipts of the Department have amounted to £9,991 13s. 1d. (including £9,082 8s. 5d. collected by Master in Lunacy), being the largest amount yet collected in any one year, and £1,100 1s. 4d. more than the collections for 1885. The cost of maintenance of patients in Hospitals was £5,113 15s. 4d. more than in the year 1885, but the average daily number of patients resident was 170, and the total number under care 125 more than during that year.

THE INSANE POPULATION OF SOUTH AUSTRALIA IN 1886.

ON December 31st, 1885, there remained in the Adelaide and Parkside Asylums 727 patients, viz., 419 males and 308 females; the admissions during the year 1886 numbered 207, viz., 116 males and 91 females, the total number treated during the year being 934, of these 74 recovered, 46 improved, 2 did not improve, 68 died, and 43 were readmitted, leaving in asylums on December 31st, 1886, 416 males and 328 females, or 744 in all. With regard to the preponderance in numbers of the male sex, it is to be borne in mind that men outnumber women in the general population of the colony to the extent of nearly 14,000 souls, and, in proportion, are more liable to be attacked by insanity. The proportion of registered insane persons to the estimated population of South Australia, on the 31st day of December, was 1 in 428; in England on the 1st day of January, 1886, it was 1 in 345. Compared with the colonies of Victoria and New South Wales the proportion per 1,000 of insane persons to general population is, South Australia, 1886—2·33; New South Wales,

1885—2·73 per 1,000; Victoria, 1885—3·25 per 1,000. Of the 207 admissions during the year only 39 were Australian born, 90 were English, 38 Irish, 16 Scotch, and 20 Germans. Of the 68 persons who died 46 were males and 22 females; the death-rate calculated on the daily average number resident is, for males, 10·9; for females, 6·8; for both sexes, 9·1. The previous year it was for males, 7·0; for females, 5·6; for both sexes, 6·4. In England, for the year 1884, calculated on the same basis, it was for males, 11·45; for females, 7·86; for both sexes, 9·51.

VITAL STATISTICS OF SOUTH AUSTRALIA FOR THE YEAR 1886.

THE births registered in South Australia during 1886, numbered 11,177 (35·32 per 1,000 of the population), against 12,046 (37·72) in 1885; the birth-rate being the lowest recorded during the past ten years. The births of males numbered 5,711; of females, 5,466. The illegitimate births numbered 266, or 2·38 to total births, and 7·3 to 1,000 unmarried women, at ages above 15 years. The deaths numbered 4,234, and exceed those of 1885 by 247. The death-rate per 1,000 of the population is 13·38; which, with the exception of 1885, is the lowest recorded in the ten years immediately preceding. Of the whole number of deaths, the males numbered 2,349, the females, 1,885; an excess of the former over the latter of 464. To 100 deaths of females the deaths of males were 124·6. The deaths of males to 1,000 of the male population were 14·4; those of females to the female population, 12·4. The death-rate of children under 5 years of age per 1,000 persons living was 40·2; the deaths of infants under one year of age, 1,409, relatively to births (11,177), are 126·0 per 1,000. Of the total number of deaths recorded, 365 were due to zymotic diseases (exclusive of diarrhoeal diseases), 328 occurred from diarrhoeal diseases, 30 from parasites, 57 from dietic diseases, 603 from constitutional diseases, 407 from developmental diseases, 1813 from local diseases, 272 from violence, and 359 from not specified causes; of the diseases above enumerated, 3 deaths were ascribed to measles, 93 to whooping cough, 13 to scarlatina, 89 to diphtheria, 93 to enteric fever, 339 to phthisis, 104 to cancer, 72 to apoplexy, 177 to convulsions, 160 to bronchitis, 180 to pneumonia, and 101 to dentition.

VITAL STATISTICS OF WESTERN AUSTRALIA FOR 1886.

THE estimated population of the colony on December 31, 1886, was 39,584, viz.:—23,044 males and 16,540 females. During the year 1886 there were registered 1,466 births,—787 males and 679 females; this is an increase of 266 on that of 1885. The number of deaths registered were 806,—525 males and 281 females; the number of deaths in 1885 was 600. The deaths under 5 years of age numbered 295 (or 36·60 per cent. to total deaths), and of these 227 were under 1 year of age. The large percentage of infant mortality is due to an epidemic of Croup, which made its appearance in the latter part of 1885; the deaths stated from this cause were 61, or 7·56 of the total deaths. 189 deaths (or 23·46 per cent.) were ascribed to zymotic diseases, 80 deaths (or 9·92 per cent.) to constitutional diseases, 289 (or 35·85 per cent.) to local diseases, 150 (or 18·61 per cent.) to developmental diseases, and 67 (or 8·32 per cent.) to violence. The principal causes of deaths were—croup 61, old age 56, heart disease 55, convulsions 48, atrophy and debility 47, dysentery 40, bronchitis 29, pneumonia 29, phthisis 24, drowning 22, fractures 20.

VITAL STATISTICS OF AUSTRALASIAN CAPITALS, 1886.

Return showing the population, the births and deaths, and their proportion to population, and the excess of births over deaths in each of the metropolitan cities of Australasia in 1886.

Capital Cities with Suburbs	Estimated Population.	Births.		Deaths.		Excess of Births over Deaths.	
		Total Number.	No. per 1,000 of the Population.	Total Number.	No. per 1,000 of the Population.	Numerical.	Centesimal.
Melbourne	371,630	12,941	34.82	7,590	20.42	5,351	70.50
Sydney	307,541	13,132	42.70	6,282	20.43	6,850	109.04
Brisbane	51,683	2,250	43.53	1,018	19.70	1,232	121.02
Adelaide	128,377†	3,826	29.82	1,837	14.31	1,989	108.27
Hobart	30,805	1,107	35.94	719	23.34	388	53.96
Wellington	27,833	1,050	37.73	487	17.50	563	115.61

† There are doubts as to whether the estimated population of Adelaide and suburbs has not been given for a somewhat larger area than that to which the returns of births and deaths relate. If this should be the case the birth and death rates of that city, as shown in the table, would obviously be lower than the true rates.

VITAL STATISTICS OF MELBOURNE AND SUBURBS FOR THE YEAR 1886.

The estimated population of Melbourne and suburbs (Greater Melbourne) about the end of the third quarter of 1886 was 371,630, the increase upon the estimate made twelve months previously being 26,250. The births in Greater Melbourne during 1886 numbered 12,941, or 34.82 to every 1,000 of the population. The birth rate was a fraction lower than that in 1885, but with that exception was higher than in any year since 1871. The number of cases of twin-births registered during 1886 was 110. As the whole number of births during the same period was 12,941 there must have been 12,831 confinements in the year, and one mother in 118 gave birth to twins. The number of children set down as being born out of wedlock during 1886 was 909, or one such birth in every 14 births registered. The deaths in Greater Melbourne in 1886 numbered 7,590, or 20.42 to every thousand of the population. This death-rate was very slightly above the average of the decade 1871 to 1880, and was above in all the years since 1880, except 1882 and 1884. The deaths exceeded by 630 those in the previous year, viz., 308 of males and 322 of females. The increase in respect of males was made up of 194 under, and 114 over, 5 years of age; and that in respect of females was made up of 270 under, and 52 over, 5 years of age. Of the births registered in 1886, 51 per cent. were of males, and 49 per cent. were of females. Of the deaths registered, 54 per cent. were of males, and 46 per cent. were of females. Children under 5 years of age contributed 41 percent. to the total mortality, as against 38 per cent. in 1885. The deaths of 349 persons, viz., 201 males and 148 females, of the age of 75 years or upwards, occurred during 1886, or 8 less than in the previous year. Of these, 170 were between 75 and 80, 99 between 80 and 85, 63 between 85 and 90, 11 between 90 and 95, 3 between 95 and 100, 1 aged 100, and 2 said to be aged 102 and 103 respectively. Of the deaths recorded during the year, 368—of which 288 were of males and 80 of females—were from external causes; 298 being ascribed to accident, 27 to homicide, 42 to suicide, and 1 to judicial hanging. 1,339 deaths, or 18 per cent. of the whole, took place in public institutions.

The deaths of children under five years of age numbered 3,119, of which 1,652 or 53 per cent. were of males, and 1,467 or 47 per cent. were of females. Of those who died, 2,309 were under one year of age, 540 were between one and two, 123 were between two and three, 77 were between three and four, and 70 were between four and five. The persons who died at a more advanced age than five years numbered 4,471; of these, 2,480, or 53 per cent., were males, and 1,991, or 47 per cent., were females.

The following table shows the causes of death in Melbourne and Suburbs during 1886:—

CAUSES OF DEATH.	NUMBER OF DEATHS.				PROPORTIONS PER CENT.	
	Males.		Females.			
	Under five years.	Over five years.	Under five years.	Over five years.		
Specific febrile or zymotic diseases ...	413	231	418	215	1,277	16.82
Parasitic diseases	2	11	4	13	30	.39
Dietic diseases	22	35	16	30	103	1.36
Constitutional diseases	112	599	99	527	1,337	17.62
Developmental diseases	150	106	104	89	449	5.92
Local diseases	599	1,223	516	1,009	3,347	44.10
Violence	43	245	20	60	368	4.85
Ill-defined and not specified causes ...	311	80	290	48	679	8.94
All causes	1,652	2,480	1,467	1,991	7,590	100.00

REPORTED MORTALITY FOR THE MONTH OF FEBRUARY, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Measles.	Number of Deaths from								
						Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	294	140	59	1	..	..	..	6	7	18	12	4	..
Suburbs	200,000	789	303	166	..	1	11	3	19	20	21	8	10	3
NEW ZEALAND.														
Auckland	88,161	77	49	35	1	..	..	..	2	15	2	..	1	..
Christchurch.....	15,265	40	27	13	..	..	..	..	1	8	1	..	1	..
Dunedin	28,245	42	17	8	..	..	..	..	..	..	..	..	..	..
Wellington	25,945	87	36	24	..	..	..	..	1	14	..	..	..	..
QUEENSLAND.														
Brisbane	82,571	125	38	27	{	..	..	4	2	17	8	8	5	2
Suburbs	41,082	157	82	40	..	..	..	..	..	..	..	..	..	..
SOUTH AUSTRALIA.														
Adelaide	318,871	809	324	162	..	2	7	3	28	43	20	16	3	9
	45,333	81	58	22	..	1	2	..	9	2	5	1	..	2
TASMANIA.														
Hobart	29,859	74	44	82	..	1	1	..	3	16	4	3	1	1
Launceston	18,906	62	34	21	..	..	4	2	4	8	1	1	1	1
Hospitals, Asylums, Gaols, &c. .	1,243	...	31	...	..	..	..	..	..	..	..	..	..	..
Country Districts.....	87,486	198	92	...	..	..	..	2	1	2	26	..	..	..
VICTORIA.														
Melbourne	69,774	178	113	{ 427	..	..	7	5	70	113	62	36	13	24
Suburbs	275,606	863	709	..	..	..	..	..	..	..	..	..	..	..

METEOROLOGICAL OBSERVATIONS FOR FEBRUARY, 1887.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.	Prevailing Wind.	
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.				
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	101·7	74·2	53·3	29·798	...	..	..
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	147	81·	69·8	57·	..	3·070	7	86
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	156·7	92·6	74·2	62·3	29·874	6·403	25	76
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	162·	92·4	62·9	40·	..	1·828	10	67
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	...	..	..	..	..	..	..	..
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	95·	62·8	39·	29·916	78	14	75
Launceston—Lat. 41° 30' S.; Long. 147° 14' E .....	...	95·	67·	41·	29·960	2·08	7	66
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E .....	...	99·6	67·9	46·7	29·856	2·67	8	..
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E .....	...	87·	70·8	58·1	29·958	4·41	18	80
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	145	78·5	63·9	46·5	..	1·428	9	76

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

THE EFFECT OF THE CLIMATE OF NEW GUINEA UPON EXOTIC RACES.

WRITTEN EXPRESSLY FOR THE *A. M. Gazette*

BY THE REV. W. G. LAWES, F.R.G.S.,
OF PORT MORESBY, NEW GUINEA.



In all that has been said and written about New Guinea during the last few years, scarcely any attention has been paid to its climate, and yet it is a subject of the first importance in considering the many schemes and proposals suggested for its colonization by a European race. The country may be rich and its resources great, but is its climate such that the white race can live there and make it a home?

The belief has been growing in my mind for a long time that New Guinea is entirely unfitted to be the home of the Anglo-Saxon, and this belief is strengthened every year. I settled here at Port Moresby, in 1874, and with the exception of a visit to England (1878-80), have been resident ever since. One round of seasons may be exceptional and misleading, but a decade of seasons is amply sufficient to show what the climate really is. I have had, during the whole time, a large number of South Sea Islanders under my care, and have had almost the sole medical care of the mission.

The entire number of South Sea Islanders who have been here since the beginning of the mission in 1872, is 201. Of these 103 have died, including 8 who were killed. It must be remembered that these were all men and women in the prime of life, between 25 and 40 years of age. They were also picked men, none being accepted for New Guinea service who had any physical weakness or disease. The 201 might reasonably have been expected in their own homes to have lived to a good old age, and yet in New Guinea 95 have died. Most of them died within 2 or 3 years of their arrival. They were all from tropical islands, such as Rarotonga, Tahiti, Savage Island,

Lifu and Mare. During the early years of the mission, when we were all alike ignorant of the climate, and the best means of preventing or treating the fever, some deaths may have occurred which were preventable. But the fact remains, that with all the care and attention which the experience of those years has taught us, there is no sensible diminution of the death-rate. The immediate cause of death has not always been fever; there have been some cases of phthisis, and some women have died in child-birth, and some cases have been obscure and difficult to diagnose. But I do not think there is one out of the 201 who escaped fever.

All the above were coloured men, Polynesians and Melanesians. How has the white race fared on New Guinea during the same period? The white immigrants have been almost entirely men, and most of them visitors rather than residents. Only five ladies have attempted to live on British New Guinea; of these, two died, and the third is just leaving now, so reduced by fever that her only hope of life is in getting away. I have just heard of the death of the Baroness von Schleinitz, in German New Guinea. She passed through Cooktown, with her husband, about a year ago, full of health and vigor. The largest number of white men who have been in New Guinea at one time, were the diggers, in 1877. Of these, several died, and the whole party was so stricken with fever that they were only anxious to get away with their lives. Of the scientists and other visitors who have been to New Guinea, almost all have suffered from fever. D'Albertis and party at Yule Island, and up the Fly River, had an experience with which almost every traveller in New Guinea is only too familiar. The deaths have not been numerous, but in most cases the patient has had an opportunity of leaving, and he has gladly taken it. From all the white men I have known to come to New Guinea since 1874, I can only say it has been the exception for any one to be here a few weeks without getting fever, and the exceptions have been very, very few. The decimation of Sir Peter Scratchley's party on the Governor Blackall, is a fair illustration of what has befallen most parties of travellers or visitors in New Guinea.

No part of New Guinea that we are acquainted with is free from fever. Inland and on the coast, on high ground and low, on the mainland and on small outlying islands, there seems no escape from malaria. Port Moresby, or as it is now to be called, Granville, is perhaps as healthy as any place we know, and that is not saying much. Men have been here in Government employ since

the proclamation of the Protectorate, who have been living for years in North Queensland, and who pooh-poohed the idea of fever, but in a few weeks they have been down with it. Working on the best site, and sheltered from the sun, with no swamp or miasma near, they have succumbed and gone down like nine-pins. Capt. Musgrave, the Deputy Commissioner here, is one of the few who have escaped fever, but then he is away on furlough three months in the year—an impossibility to those who come to New Guinea to make a living.

The fever may be called the New Guinea fever, for while it has much in common with other malarial fevers, there are some characteristics which distinguish it as endemic to New Guinea. It assumes different forms. We have the simple intermittent fever and ague. This, though often very severe, is the most tractable and the most amenable to treatment. The more pronounced the cold stage, the more regular are the others, and the more thorough the recovery in the interval. A remittent type is very difficult to deal with. In these cases there is no cold stage and no violent symptoms, but a total loss of appetite, great depression, and continual fever. The Rev. Mr. Sharpe, who died in Cooktown from fever contracted here last year, had this remittent fever more than a fortnight before he left for Cooktown. Day after day he seemed just about the same. His temperature in the morning was just over 100°, and in the evening 102° and 103°. He slept well, had no vomiting, but loathed all food, and got gradually weaker. This is a typical case.

But there is another form which seems to partake of the character of both intermittent and remittent. The cold stage is not very marked, the hot stage prolonged, and symptoms very violent; at length the sweating stage comes on, but is soon over, and brings very little relief. Long before the proper time the fever returns, and then it is the same thing over again. In these cases vomiting is often very severe, enormous quantities of pure bile being thrown up.

No age or condition is free. My own infant, who was born here, had his first attack of fever when he was six weeks old, and from that time until his death at eighteen months, he was constantly the subject of fever and ague. In the case of children especially, the spleen becomes very much enlarged. The natives suffer from fever, but the symptoms are not often violent. Dogs undoubtedly have it, one dog we had used to shiver, and go and lie in the sun, and then came the hot stage, with dry burning nose. I don't know whether it ended in sweating; it lasted a few hours, and used to return at regular intervals. Those who become acclimatized are liable to frequent returns of a milder form of fever

and ague. I am writing, not only from my observation of those who have been my patients, but from my own personal experience.

I hardly like, as a non-professional, to say anything about treatment. Our resources are very limited. Those who do not know by experience what tinned meats are, can scarcely imagine how difficult it is to tempt a fickle appetite, or keep up the strength of a patient with them. Next to quinine, Liebig's extract of beef is our greatest necessity. And what would we not give for ice, or even *cold water*? The very large doses of quinine recommended by some practitioners in India have not been a success in my hands. I have found about 15 grs. a day the best quantity with myself, and most of my patients. Some, who can never keep down quinine in a liquid form, take it easily in gelatine covered pills. Arsenic I have found of great service with some, after the recurrence has been broken by quinine. The vomiting almost always yields to hydrocyanic acid. My attention was called last year by Mr. H. O. Forbes to Warburg's fever tincture, and I have tried it with great success. My supply was but limited, but no case in which I took or administered it did it fail; it has a high reputation in India, and I believe will be as successful in the treatment of New Guinea fever.

There are but few diseases besides fever which need any notice. Ulcers are the most common affliction of the natives. Children almost all have, during some period of childhood, the skin disease, known in Eastern Polynesia as *tona*, and which resembles framboesia; these sores, however, often develop into corroding ulcers, from which many infants die. A form of leprosy is endemic in some places in this neighbourhood. In white men the smallest wound becomes a troublesome sore, very difficult to heal.

Syphilis is certainly unknown among the natives, I have always been on the look out for signs of its existence, and it could not possibly have been hidden if any men had been so afflicted. I fear it has been introduced within the last two years at a village about forty miles from here, but the surprise and disgust of the natives is strong corroborative proof that they were previously unacquainted with it.

Ophthalmia is uncommon, isolated cases occur, but it is not epidemic as it often is in the South Sea Islands, nor yet of so virulent a type.

If blight was common, as it is in Queensland, there would be much blindness, for the habits of the people would increase rather than cure it. The proportion of blind to the population is very, very small.

Port Moresby, New Guinea,
March 19, 1887.

CASE OF CEREBELLAR TUMOURS,
COMPLICATED BY TYPHOID FEVER.
DEATH. AUTOPSY.

REPORTED BY W. R. CLAY, M.R.C.S., L.R.C.P.
LOND., RESIDENT MEDICAL OFFICER AT THE
SYDNEY HOSPITAL.

R. M., aged 24, a linen manufacturer, admitted to the Sydney Hospital on December 9th, 1886, under the care of Dr. Kyngdon.

HISTORY: Five years ago had a single chancre with enlarged glands in both groins, but no other signs of syphilis.

Two years ago had a severe attack of "some liver disease," during the course of which he became completely blind. His sight soon improved, and at times he could see fairly well. Every few months after this his sight became very dim for several days at a time.

A year ago his gait became staggering, his sight became worse, and he had general weakness.

He left England in a sailing ship in the month of August, and for three weeks was very well, his sight being better than it had been for some time. He then began to suffer from obstinate constipation, the staggering got worse than ever and he could only tell light from darkness. Remained in much the same state till the ship's arrival at Sydney. He was brought to the hospital four days after arrival; in the meantime he had been on shore once to consult a medical man.

STATE ON ADMISSION.—Gait staggering. T. 105°, P. 110, R. 30. Tongue moist, red at edges. Eyelids closed, pupils very dilated, act slightly to light, cannot discern light. Slight paralysis of left facial nerve. Deep reflexes exaggerated, superficial diminished. Abdomen distended and tympanitic. Milk diet, cold sponging, and a mixture containing ten grains of Iodide of Sodium ordered.

Dec. 10th.—Very restless, has no control over sphincters, motions light colored.

Dec. 11th.—T. 105° for the last 48 hours, except an intermission of two hours at 103°. Placed in a bath at 95°, which was then cooled to 85°; Temp. after bath was 102°. Slept well all the afternoon and evening, this being the first sleep since admission. Temp. rose to 104.8° in the evening, but fell very soon below 103°. Diarrhoea continues, stools typhoid in character.

Dec. 12th.—Slightly delirious last night.

Dec. 13th.—Slight haemorrhage from the bowels, abdomen very tender.

Dec. 14th.—Haemorrhage twice; four spots, which are faint and easily fade on pressure, visible on abdomen, which is very distended. Turpentine mixture ordered.

Dec. 15th.—Slight haemorrhage, diarrhoea continues, temp. rose to 103° for the first time since Dec. 11th. Can differentiate light and darkness.

Dec. 16th.—Spots disappeared, slept well, temp. below 100°.

Dec. 20th.—Motions still passed involuntarily, bladder acts naturally. Temp. 99°.

Dec. 27th.—Motions passed voluntarily, pupils very dilated, temp. normal for a week.

Dec. 29th.—Pupils less dilated, can see the outline of anyone close to him. Fish diet.

Jan. 2.—Pupils very dilated, cannot see anything.

Jan. 6th.—Ophthalmoscopic examination by Dr. Maher. Slight hyperæmia of palpebral conjunctiva. Media normal. Pupils dilated to about 9 millimetres. Right pupil acts slightly to the action of light. Right optic disc atrophic, veins tortuous and somewhat contracted. Arteries tortuous, but not so much as the veins, and slightly contracted. Left disc pale, margin hazy, evidently undergoing atrophy secondary to neuritis, vessels the same as in the right side.

Jan. 10th.—Gets up, gait very staggering. Is taking large doses of Pot. Iodid.

Feb. 3rd.—Temp. suddenly rose to 102°, having been normal since Dec. 20th.

Feb. 6th.—Temp. rises at night. Tongue slightly furred. Skin hot and dry.

Feb. 7th.—Very restless. Pulse dicrotic very fast, T. 105°, wet pack applied, which reduced the temp. 3 degrees. Brandy mixture ordered.

Feb. 8th.—T. 105°, reduced to 103° after being in the wet pack for 3 hours. Tongue brown and very dry at edges. Slightly delirious. Lies in apathetic condition.

Feb. 9th.—T. 105°. Feet very cold, pulse almost imperceptible. Taking a large amount of stimulant. Passes urine involuntarily.

Feb. 10th.—Temp. only down while in the wet pack. Is conscious, answers questions incoherently. Motions passed involuntarily.

Feb. 11th.—Very drowsy and apathetic. Bed sore forming.

Feb. 12th.—T. 106, reduced to 103.8, but it soon went up again, and patient died at 1.50 p.m., having been comatose for 24 hours.

P. M.—Twenty-two hours after death.

Thorax: Firm bands of adhesions unite the surfaces of the pleura at the left apex and the left base.

Extensive but less firm adhesions at lateral aspect of right lung.

Both lungs dark red posteriorally, engorged with blood, which can be pressed out on section; only slightly crepitant, floats in water.

Heart: Weight 9½ oz. Endocardium and inner coat of large arteries of a dark red colour,

this is very marked in the aortic and pulmonary semilunar valves.

Abdomen : Peritoneal coat pale in color. Small intestine contains light yellow-colored semifluid faecal matter. In lower three feet of ileum the solitary glands are very prominent, appearing as small red projections thickly studding the mucous membrane. On the surface opposite the mesenteric attachment, are several of Peyer's patches, their outline clearly mapped out, and of a pink color with injected vessels. In similar situations are other patches of a dark brown color, with raised edges. Mucous membrane soft and easily detached from the patch, and in some there are small circular ulcers.

Spleen : Measure 8 x 6 inches. Engorged with blood and very friable.

Liver : Weight 4lbs. 8oz. On section presents fatty appearance.

Kidneys : Capsule peels easily, slightly enlarged, fatty.

Brain : Puncta cruenta well marked. Lateral and third ventricles distended with serous fluid. Foramen of Munro about $\frac{1}{4}$ -inch in diameter. Vena Galeni and vena corporis striati of left side very much enlarged.

Cerebellum : In the middle line on the inferior surface, and just behind medulla oblongata (in nodule and part of uvula), is a hard mass the size of a walnut, its centre being a channel about one inch long, and a quarter-inch in diameter, extending antero-posteriorally, and filled with dark blood clot. On the left side, in the position of the tonsil, there is a hard circumscribed tumour, about the size of a hazel nut. Behind the latter and close to it, in the digastric lobe, there is another tumour the size of a pea, it is hard and contains small calcareous plates.

Spinal cord : Blood vessels of pia-mater engorged. Embedded in the posterior part of the pia-mater at the lower part of the lumbar enlargement are several greyish flat bodies, firm in consistence, and occupy a space about $\frac{1}{4}$ -inch square.

A similar body present on the posterior aspect of the cord at the lower dorsal region.

Central canal of cord enlarged.

REMARKS.—This case appears to be of peculiar interest, as the typhoid fever complicated the diagnosis of a cerebellar tumour.

On admission, the patient was probably at the end of the second week of typhoid, judging from the temperature and haemorrhage, which latter was too copious to have taken place before that time. The temperature must have been affected by the tumour, as the intestinal lesions, although perfectly conclusive of two attacks of typhoid, were hardly sufficient to cause so much elevation, especially noticeable in the relapse.

It is rather remarkable that the patient contracted typhoid at such a period, as the ship must have been at least three months at sea, and no one else on board suffered any effects from bad water or ventilation.

With regard to treatment, the cold bath appeared to have a marked effect not only in reducing the temperature but also in inducing sleep.

The bath was not resorted to in the relapse, as the patient was almost in a state of collapse from the beginning, but the cold wet packs reduced the temperature temporarily.

Although a microscopical examination was not made, the tumours, from their appearance and the fact of their being multiple, were probably syphilitic.

The patient denied having had any secondary syphilis, except the enlarged glands, but I think there are numerous cases recorded in which secondary symptoms have not been present or in which they had escaped notice.

The cause of death was coma, due to the pressure of the tumour on the left vena Galeni and consequent distention of the ventricles.

NOTES OF A CASE IN WHICH PUERPERAL INSANITY OCCURRED DURING PREGNANCY.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH
B.M.A.

By W. T. HAYWARD, M.R.C.S.,
Norwood (ADELAIDE).

PUERPERAL insanity developing during pregnancy is, in my experience, so comparatively rare, and presents, as regards its treatment, points of so great importance ethically, that I have deemed the notes of the following case worthy of being brought under your notice.

The husband of my patient, Mrs. E., consulted me about his wife, who, he said, was developing a suicidal tendency. As a result of questioning both him and her, and from my previous knowledge of the case, I gained the following history :—

Mrs. E., aged 24, a bright, pleasant, cheerful little woman, fair complexion, and curly hair, has a comfortable home, no domestic troubles, has always enjoyed the best of health, and there is not the slightest history of any nerve disease in the family. Shortly after marriage became pregnant, and did not seem to suffer more than the usual inconveniences attendant on that condition till within two months of her expected accouchement, when she began to manifest great fear as to the result of the approaching event, became low-spirited, and had a great objection to being left by herself night or day, the reason for which she subsequently confided to her husband was, that when alone the temptation to commit suicide

became very strong, and she begged him to keep his razors locked up. No one but the husband knew of these feelings, and I was not told of them. Labour came on at the proper time and she did very well; I attended her and did not notice anything peculiar in her mental condition. She says that the nervous symptoms completely passed away when the baby was born, and she had no return of them during the period of lactation (six months), during this time I had occasion to see her comparatively frequently, and I subsequently attended her for a mild attack of typhoid fever; from the knowledge of her I thereby gained, I should have thought that she would have been one of the last who would have suffered from melancholia. On recovering from typhoid fever the menses reappeared, and continued regularly for seven or eight months, when they ceased. Barely a fortnight had elapsed after the last menstrual period before symptoms of melancholia, similar to those she had endured during the latter part of her previous pregnancy, appeared, and shortly after the suicidal tendency began to manifest itself, she herself told me that it was rarely absent from her mind, and at times the inclination to do away with herself was so strong that she could hardly repress it. It was about this time that I was consulted. I endeavoured by moral, hygienic and tonic treatment to mitigate the symptoms but without success, if anything the tendency increased rather than diminished with paroxysmal exacerbations, these paroxysms when passed would be followed by intense mental agony, with loathing of herself for the crime she had escaped. This state of affairs had continued for a month, when one day Mr. E. called on me saying that on the previous evening his wife came to his place of business, and going with her into his office she burst out in a flood of tears and confessed that she had just come from the Torrens Lake where she had intended to drown herself, and had walked into the water (her clothes corroborated this), but had been enabled by a supreme effort to overcome the temptation. He also informed me that on looking through her writing-desk he had found, carefully cut out and put away, newspaper slips recounting the cases of two suicides under similar circumstances, you will doubtless remember the incidents, one occurred at the Semaphore and the other in Angas-street. I felt a great responsibility rested upon me, and would rest upon me should my patient commit suicide, and there were six more months to run. After most anxious consideration I decided to induce abortion, which, on being successfully practised by aid of a gum elastic catheter, had the effect of at once and completely relieving the symptoms.

Was the course I pursued a right one, and was

it correct treatment to induce abortion? These questions have more than once presented themselves to me, and though I conscientiously did what I considered right, yet I should be glad to have the opinion of some of my professional brethren, so that, should I at any future time be placed in a similar position, I might be justified in, or dissuaded from, the course of action that I have related.

PURULENT OPHTHALMIA IN NEWLY-BORN CHILDREN.

(READ BEFORE THE S. A. BRANCH, B.M.A.)

BY M. J. SYMONS, M.D., HON. OPHTHALMIC SURGEON OF THE ADELAIDE HOSPITAL.

I CRAVE your indulgence for a few minutes on a subject with which you are doubtless all familiar, but one which has great bearing in regard to the future population of our colony, namely, the purulent ophthalmia of recently-born children.

I have no hesitation in stating that about one-third of the inhabitants of the blind asylums of civilized people owe their condition to this disease; also that it is one of the most certainly preventable of the diseases which destroy vision.

The statistics on this subject in our own colony I am unable to give, but the number of cases which have come under my own observation urge upon me the duty of begging you to do your utmost towards its eradication, towards the averting of the evils it entails upon its victims, and towards the mitigation of the injury done to our colony by the presence of a proportion of our fellow-colonists who have been rendered unable to support themselves by a disease which the action of this society may banish from our midst.

Let us look at the disease from a point of view regarding its preventability, its definite symptoms, and its efficacious treatment.

There can be little doubt that the secretion from the maternal passages is the great cause. The almost universal presence of purulent discharge at the os uteri during parturition, the frequency of leucorrhœal and the possibility of the existence of a specific discharge, present us with sufficient instances of the sources to which we may attribute the occurrence of ophthalmia neonatorum; indeed it is to the firm closure of the eyelids and the approximation of the skin surfaces we must attribute the fact that so many infants escape infection.

The leading characteristic of the disease is:—pus exuding from the eyelids in children under a couple of weeks old.

The disease generally begins with a red line along the margin of the eyelids, followed rapidly

by swelling, redness and heat of the lids, especially the upper lid, with a serous secretion which glues the lids together; later the discharge becomes puriform, and its flow prevents glueing of the lids. Now we have the disease pronounced and in a condition when it must be energetically coped with if we would save the vision. Chemosis of the ocular conjunctivæ follows, and by its pressure upon the deeper vessels—too frequently aided by malnutrition or constitutional debility, soon determines ulceration or necrosis and sloughing of the cornea—the corneal texture gives way and the eye is practically lost.

The treatment may be divided into two stages: 1st.—The cornea is clear while the cornea is yet unaffected, cold or iced applications should be assiduously maintained. The discharge should be washed away as freely as it is secreted.

The inflamed surfaces should be rendered as nearly antiseptic as possible. This is fully met by means of a solution of corrosive sublimate (gr. i ad. ʒviii) poured freely within the eyelids for a few minutes in every hour day and night, and after each pouring in of the solution, dry levigated iodofrom should be freely dusted over the palpebral conjunctivæ. Whilst this line of treatment is being pursued it will be necessary to attack the disease itself by the application to the everted lids of a solution of nitrate of silver (grs. v ad. ʒi) every three or four hours, or a solution of nitrate of silver (grs. xx ad. ʒi) daily, the excess being neutralized by salt solution once, and drops of chloride of zinc (grs. ii ad. ʒi) every three or four hours day and night. The surgeon should personally apply the caustics.

2nd.—The cornea is involved. In this case the endeavour must be to cut short the progress of the disease by urgent means. To effect this we have recourse to the mitigated stick of nitrate of silver and potash (one in three) with which the palpebral conjunctivæ is to be so touched as to destroy the epithelial lining from which the pus is secreted, the excess being neutralized by salt solution. The application of the mitigated stick may require repetition every twelve to twenty-four hours; but it should never be used until the slough of the previous application has been thrown off and the secretion of pus is re-established, otherwise the denuded basement membrane will be destroyed and unnecessary scarring produced. Chemosis of the conjunctivæ should be scarified to relieve pressure. It will always be advisable to instil atropine to place the iris in the safer position of full dilatation, so that the risk of prolapse may be less should the cornea give way. I need scarcely remind you of the dangers of contagion, and the precautions to be observed against such a calamity.

I have found the free use of levigated iodofrom so valuable an adjunct as almost to regard it as a principal in the treatment of Purulent Ophthalmia.

Now, gentlemen, to approach the main question to which I desire to draw your attention, namely, how to minimize the occurrence of a disease, undoubtedly preventable by the exercise of care in its incipiency.

A little over three years ago the Ophthalmological Society of the United Kingdom made an endeavour through the medium of the poor-law and Birth Registrations Organizations of Great Britain to stamp out this scourge.

The resolution passed by that Society was as follows:—

"That the Purulent Ophthalmia of new-born infants being the cause of a vast amount of blindness, mainly because of the ignorance of the public regarding its dangerous character and the subsequent neglect to apply for timely medical aid, it is desirable to instruct those in charge of new-born infants by a card in substance as follows:—

"Instructions regarding new-born infants:—If the child's eyelids become red and swollen, or begin to run with matter within a few days of its birth, it is to be taken without a day's delay to a doctor. The disease is very dangerous, and if not at once treated may destroy the sight of both eyes."

Unfortunately this highly proper and humane endeavour did not obtain the result it merited. Mr. President, I have hopes that having brought this subject to your notice, a more fortunate result will be gained, and some practical advantage secured should we be able to set in motion the authority of the Board of Health in order to disseminate throughout this colony a note of warning as to the dangers with which the first symptoms of discharge from the eyes of infants is fraught, and also to advise those having the care of infants as to what course to pursue during the oftentimes necessarily long interval before skilled advice can be obtained.

To effect this object I would propose that this Society suggest to the Board of Health that the Board should take such steps as appear advisable to bring before the public the dangers of Ophthalmia in new-born children, accompanied by the following advice:—

1st.—That the eyes of every new-born infant should be specially cleansed immediately after the general washing.

2nd.—In case of any discharge from the eyes being noticed it should be washed away as freely as it appears with a lotion composed of one teaspoonful of borax to one teacupful of cold water.

3rd.—That medical aid should be obtained as soon as possible.

CASE OF HYDATID OF THE LIVER
IN A CHILD.

(UNDER THE CARE OF DR. VERC.)

REPORTED BY A. P. VAUGHAN, M.B. ET CH. B.,
MELB., HOUSE-SURGEON AT THE ADELAIDE
CHILDREN'S HOSPITAL.

HISTORY.—Eliza C., set. 8 years. A lump has been noticed in her right side for about two months. Child never complained in any way till a fortnight ago, when her stomach seemed out of order and she vomited after food.

2-11.—On admission temperature 99·4 ; Child is rather thin. On inspection the right side of the chest is bulged from the clavicle to the margin of the ribs ; and the abdomen in the right hypochondrium, the most prominent point being just inside the nipple line, half an inch below the rib margins. The heart's apex beat is half an inch outside the nipple line in the fourth interspace. There is dulness in the left nipple line at the sixth rib, running straight out into the left mid-axillary region. Dulness begins absolutely at the fourth space in the right nipple line. Comparative dulness begins in the third space and runs straight out into the mid-axillary region.

THE ABDOMEN.—Liver dulness extends in the middle line as far as one inch above the umbilicus—in the axillary line, just about to the level of the umbilicus, rising obliquely upwards and to the right so as to reach the rib margins about the posterior axillary line. The notch of the liver is in the middle line. The left lobe is obscurely felt in the left hypochondrium, running in a curved direction to about the mid-axillary line ; it is soft. The tumour is tense and elastic. Posteriorly the chest is resonant. There are a few dilated superficial veins over the tumour, but no dropsey or other signs of obstruction of venous return. Complains of no pain, or other symptom, beyond some loss of appetite. Urine, acid—no albumen.

4-11.—Anæsthetised with chloroform and ether. Dr. Verco, assisted by Dr. Lendon, performed abdominal section. The incision was made over the most prominent part of the tumour and extended from the rib margins downwards, and a little inwards, for about two and a half inches. The tumour was fixed in the wound by two silk ligatures passed through it parallel to one another—the fluid contents evacuated to a great extent by a canula and syphon tube. An incision was made in the median line ; the divided edges of the adventitia were stitched to the edges of the wound in the abdominal wall, catgut ligatures being used. The cyst was then removed through the aperture, a large drainage tube put in, and the wound dressed with a large carbolised gauze dressing. Strict

antiseptic precautions were adopted throughout the operation. Vomited during the evening.

5-11.—Is rather restless. There has been a profuse soaking of clear fluid from under the dressing. When dressed under the spray, the pads were found to be stained with bile.

6-11.—Slept well. Dressings bile-stained. Has a feeling of nausea and some local pain.

7-11.—Did not have a good night. Bowels regular. Syringed cavity with 1-50 carbolic lotion, which came out quite clear. Urine acid, sp. gr. 1006. No albumen.

8-11.—Hardly any discharge from cavity to-day. Syringed with acid boracic 1-40 lotion, which came away bile-tinged. Bowels open frequently ; motions white and green ; vomited bilious matter once. Had convulsions, with rising temperature, increasing rapidity of pulse and respiration, and deepening loss of consciousness, and died that afternoon.

AUTOPSY.—There was no sign of peritonitis. The lungs were normal ; little hypostatic congestion. No pleural adhesions. Heart normal ; firm straw-coloured clots on right side. Kidneys and spleen normal. Brain normal.

The cyst of the liver was united by catgut sutures to the abdominal wall, at the seat of the section, some injection just around it, and complete union by recent lymph. The hydatid was found to have excavated the whole of the right lobe of the liver, and to have formed firm adhesions with the diaphragm. It had a thick, whitish, rather gristly wall, stained inside of a saffron color with bile. There were two small hydatid cysts inside it—one about the size of a small walnut, the other of a bean. The walls of the cavity had folded together over a considerable area, especially at the outer and back part, so that the opposed surfaces had come together, and here lymph had been poured out, which had united the surfaces by plastic adhesion, and had to this extent obliterated the sac.

I bring forward this specimen because it throws a clear and interesting light upon the closure of the large cysts which exist after the evacuation of an hydatid. It proves conclusively that when by free incision all the contents are removed, if the cyst walls are thin and supple enough, the pressure of the abdominal walls through the medium of the abdominal viscera, will bring the opposite surfaces of the cyst into contact, and where they can remain in apposition, plastic lymph will be exuded, and without any suppuration or granulation this will organise, and within a few days obliterate a large area of the cyst by primary adhesion. It need hardly be pointed out how much more rapid must such closure be than the filling up of so large a cavity by the tedious process of

suppuration and granulation. It is the difference between the primary and the secondary healing of a wound. Also that such a primary adhesion is only possible when there is complete evacuation of the sac and removal of the mother cyst, and therefore cannot be attained when there is puncture with the large trochar and canula, and the gradual extraction, during the course of many days, of the broken down debris of the hydatid. In such case this debris would intervene between the walls of the sac and prevent apposition and therefore adhesion. This is evidently a strong argument in favor of free incision, and, where the trochar is used, immediate dilatation and extraction of the mother cyst. It is also a contra-indication to the distension of these hydatid sacs in the subsequent washing out ; for such distension is liable to break down again these recent adhesions, and so retard the process of cure. In injecting them with medicated fluids, avoid all force, and allow the liquid to flow out as freely as it will.

TWO CASES OF MENINGITIS—ACUTE AND CHRONIC—BOTH TERMINATING FATALLY.

By T. B. WHITTON, M.D., &c.,
REEFTON, NEW ZEALAND.

As these two cases have presented several interesting features in common, I considered it worth while fully recording them.

I.—ACUTE IDIOPATHIC MENINGITIS.

History.—Miss C.—, aged 15, a healthy female, possessing a good family history, with no neurotic taint ; father very active and robust, one of a family of 11 persons, the remainder of whom are alive and in good health. She never had been ill, nor sustained any injury ; engaged in assisting her aunt in the management of her father's house. Menses occurred two years ago, and regular in every respect ; no traces of ever having received a fright, or of being crossed in love, &c. Her aunt informed me that for some nights previous to her being taken ill she had not slept well, and that she attributed it to sleeping in the same room with a friend who was supposed to be of an insane temperament.

When called to see her on July 10th, 1886, she was in bed, suffering from severe frontal headache, vomiting a dark yellow fluid every 3 or 4 hours, occurring in sudden gushes of about half-a-pint, acid, and of a sweet chloroform-like odour ; lying on her face, with the head buried in the pillow, constantly moaning and complaining of the light and the noise of the household, unable

to retain anything on her stomach, or to sit up in bed.

Temp. 99, pulse 72, tongue thickly furred and coated, bowels regular until to-day, urine with an intense deposit of lithates—no albumen present. No heart or lung complication. The tâche cérébrale was obtainable over the chest and abdomen until the 10th day, when it disappeared.

Treatment.—She was given Ammon. Brom. and Sod. Brom. grs. x each, with Aq. Lauro Cerasi 3 i every two hours, and grs. v pil. Col. Co. An evaporating lotion to be kept constantly applied to the head and the room to be darkened, no food allowed, and to drink only barley-water and milk.

July 11 and 12.—Vomiting not so frequent, and not in such quantity as before ; cephalalgia not so severe ; anxious for food, but allowed only the milk and barley-water ; bowels unmoved, though the Col. Co. has been increased, and Castor Oil and Eno's Fruit Salt taken on her own responsibility ; temp. normal, and pulse 75.

July 13.—Bowels moved slightly ; has only vomited twice to day, and of an acrid, mucous appearance ; pulse and temperature the same. She sat up a few hours in the bed to-day as the headache was very slight.

July 14.—I was sent for in the morning to see her. She had suddenly become very wild and excitable during the night, face flushed, and conjunctiva injected ; temp. 100, and pulse 80 ; skin dry and burning ; intense cephalalgia, which she cannot localise ; conscious, replies calmly and rationally to all questions, but her constant refrain is, "my head, oh! my head!" varied with a shriek, a call for her aunt, or an imaginary squabble with some of her brothers or sisters. The vomiting has not returned ; a trace of albumen in the urine, and the lithates in the same quantity. Ordered her an enemata morning and evening, but it was ineffectual. Her head has been shaved, and it rests upon an air pillow and kept constantly moist with a lotion of Amm. Chlor., Pot. Nit. and Spts. Meth. The Bromide mist has been discontinued, and Pot. Iod. grs. v, and Ammon. Carb. grs. x, given every two hours.

July 15.—T. 103, P. 85. Bowels unmoved ; enemata repeated in the morning with an increased quantity of Castor Oil and Ol. Tereb. ; but as it proved ineffectual m iii Ol. Tiglia were given at 10 o'clock. Extreme restlessness and very uncontrollable—she has to be forcibly restrained in the bed ; drinks greedily of soda or barley water. The heat of the head is such that the lotion-cloth becomes dry in 20 minutes. Injected hypodermically gr. $\frac{1}{10}$ Pilocarpine at mid-day, which induced free perspiration. Continue the Pot. Iod. mixture.

July 16.—M. { T. 102 E. { 103·2
P. 100 120

Free purging this morning; repeat the injection of gr. $\frac{1}{10}$ Pilocarpine. Though the Croton Oil and Pilocarpine had reduced the temperature and pulse in the morning, it increased again by the evening, and so continued until death. Today the cephalalgia and excitability were at the highest, very loquacious, calling constantly for unreasonable foods or drinks, and refusing to be attended by certain members of the family.

July 17.—M. { T. 103·2 E. { 103·2
P. 120 128

mii Ol. Tiglii were given this morning, and Calomel grs. ii at night; gr. $\frac{1}{10}$ Pilocarpine injected. The kidneys, bowels and skin are all acting freely. She is quieter to-day; headache less, and takes freely what is given her.

July 18.—M. { T. 103 E. { 103·6
P. 128 135

Calomel and Pilocarpine were both repeated this morning. The effect of the latter is very slight, the skin becoming as dry as before in two hours. The Iod. Pot. mixture continued as usual.

July 19 & 20.—M. { T. 102·8 E. { 103
P. 120 120

Pilocarpine injection repeated, but the effect passed away in half-an-hour. Calomel was discontinued as diarrhoea threatened—it had not produced salivation. Both albumen and lithates present in a large quantity. During these two days cephalalgia and excitability have ceased; apathetic to her friends, but is conscious and recognises them.

July 21.—M. { T. 103 E. { 104
P. 125 125

The second stage of meningitis has now been reached. She is lying on her back in a semi-conscious state, requiring great persuasion to take any nourishment, which is given now in the form of chicken broth, champagne, &c. Paralysis of the bladder, which required passing of the catheter. Respiration 28 per minute; both pupils dilated; no strabismus, but convulsive movements of the muscles of left leg occurred to-day. Ceased all medicines except the Pot. Iod.

July 22.—M. { T. 103·5 E. { 104 R. 32
P. 128 130

Answers to-day if loudly spoken to; no recognition of friends; paralysis of left arm and leg has taken place, lying in the same position, but passing urine and faeces involuntarily. Condition hopeless.

July 23.—M. { T. 104 E. { 104·8 R. 36
P. 130 135

Comatose; pulse rapid, thready, and fluttering; temperature rising; pupils widely dilated; tongue dry and brown; paralysis unaltered.

She died at 7.30 a.m. on the following morning. Temperature 106 half-an-hour after death. No. P. M. was obtainable.

CASE II.—CHRONIC MENINGITIS.

EDWARD T., aged 49. This man, who was in active work as a miner before Christmas, was noticed by the proprietor of the hotel at which he was boarding to have latterly become restless, getting up at 4 o'clock a.m., wandering about the house, and only partaking of food after extreme persuasion. He was very uncommunicative, silent, and sitting all day by himself; when asked if he was sick or in pain, he replied, after a few moments staring at the questioner, in the negative. He had not been drinking, and his mates gave him the character of being a sober, quiet and hard-working man. On his ceasing to take any food the police were communicated with, who removed him to the district hospital, where I saw him for the first time on Jan. 9th, 1887.

On his admission his clothes had to be forcibly removed off him, and he had to be restrained in bed as he said that he was not ill; he complained of no pain, except cephalalgia, neither was he hungry or thirsty, and he would not partake of any food, until an Indian-rubber catheter was passed down the throat through the nose. Tongue very foul; the breath possessing a sweetish odour, which disappeared on the third day, and was followed by an abominable stench, which grew worse before death. Urine, normal sp. gr., dark coloured; no albumen or lithates; temp. 101, pulse 140; respiration normal; weight 9 stone 4 lbs. He was greatly emaciated, the intercostals, recti and other muscles standing out in great relief; no rose spots or any rash visible. The skin was dry and harsh, and the arcus senilis well marked in both eyes. As he continued very restless and excited Morph. Bimecon. gr. i was injected.

Jan. 10th.—He has slept soundly all night, is quiet, and answers rationally; the cephalalgia is still persistent, it never increased, but was present until death. He was always quiet and sensible in the mornings, but by the evenings, as the temp. rose a degree or two, which it always did for the following five days, he became very restless, suspicious and watchful, trying to get out of bed, and if allowed so to do he walked with a staggering gait, as if drunk; he was always able to go to stool, &c., to the last. He most obstinately refused food of every description, and it was by force only that he could be managed to swallow it, he said that he did not require it, that it had a nasty taste. The diet consisted of soda water and milk, beef tea, egg and milk, and an ounce of whiskey thrice daily. Evening temp. 100, an increase of 1; pulse 150, a rise of 10 beats since morning; Morph. gr. $\frac{1}{2}$, injected 9 p.m.

Jan. 11th.—Sitting up in bed this morning, with his hands clasped behind his head, which was his favorite attitude. He maintained to-day that he was God Almighty, and that he did not require any food, and which he would not allow into his mouth until threatened with the catheter. A minute examination was made for the typhoid rash, but none was visible; the abdomen was tympanitic, not tender, and he said that his bowels had not been moved for the last four days; given Pil. Col. Co. grs. xii. All the reflexes and the knee joint were normal; hyperesthesia of both thighs and legs was noticed; the tâche cérébrale well marked over the abdomen, and myoedema on tapping the pectoralis major, or the intercostal muscles. Evening temp. 100, risen 1; pulse 155, increased by 5 beats since morning; no Morphia to-night.

Jan. 12th.—Has vomited during the night bilious looking fluid, mixed with undigested food; vomiting of the same character occurred on various occasions during the next twelve days; tongue and teeth very foul, and the mouth in such a filthy state as to require a daily syringing with Condy's fluid, &c., but all to no purpose, for by the following morning he stank as offensively as ever. As the bowels were unmoved he was given an enemata, and as this likewise proved ineffectual, he was given next morning $\frac{1}{4}$ Ol. Tiglili, in a gelatine capsule. Evening temp. 99, no increase; pulse 140, having fallen 15 since morning.

Jan. 13th.—He remains in the same condition; slight return of vomiting, but no delusions; gave an account of himself, birthplace, &c. The temp. has fallen to 97, and the pulse to 120; he was given Pot. Iod. grs. v, Ammon. Carb. grs. x, and Sod. Brom. grs. v, ter in die; and as during the night he would lie awake in a restless, watchful state, he was given Hyd. Chloral grs. xv, increased to grs. xxx, but as it did not produce sleep or quietness it was stopped. To-day and on the three following days, he had an injection of gr. $\frac{1}{10}$ Pilocarpine, causing both perspiration and salivation in four minutes; the latter had the effect of cleaning the tongue, but only for that day, as on each morning after it was as furred as before. The Pilocarpine had no effect upon reducing the temp., in easing the cephalgia, or inducing sleep, &c., the depression produced by it causing him to be less restless and obstinate for a few hours only after its injection.

Jan. 18th to 22nd.—During this interval he remained without any alteration; temp. ranging from 97 to 99, and the pulse 108-120; Ol. Tiglili $\frac{1}{4}$ ii was given occasionally; vomiting returned on four or five occasions. He has lost flesh rapidly, his weight on the 24th was 7 stone 9 lbs. The slightest tap of the finger on any muscle over

the chest walls produced myoedema; the Pilocarpine was increased to gr. $\frac{1}{2}$, but its effect was as formerly.

Jan. 25th.—Temp. 100, pulse 120, very weak; more obstinate than ever in regard to food; is greatly emaciated; intellectual faculties very dull. To-day he had an epileptiform attack, which lasted about 20 minutes; no spasms, paralysis, strabismus, or twitchings having hitherto occurred. He died quietly at 5 a.m. next morning.

On *post-mortem* examination the cerebral dura mater was thickened and firm, like to parchment, and adherent to the arachnoid for about two inches in width, on each side of the longitudinal fissure; underneath this part of the adherent membranes was a soft, non-purulent exudation; there was no adhesion of the dura mater to the skull, its colour was a dull grey; there was no tumour, clot, softening, or any lesion of the skull, cerebrum or cerebellum; the arachnoid was opaque, dull grey, and adherent to the pia mater, both full of serous effusion, and easily stripped off the convolutions and sulci. Ventricles normal, serum of which was turbid. The convexity of the cerebral hemispheres, when stripped of its membranes, was harder than normal, or section; the convolutions standing out in marked relief, and giving one the impression that it had been preserved in spirits for some days before examination; base of the brain normal; no lesion in any other organ.

Remarks.—Acute idiopathic meningitis is an exceedingly fatal disease, to which Miss C.'s case was no exception. Its sudden onset, without any assignable cause; the vomiting; the obstinate constipation; the cephalgia; the uselessness of drugs, and the gradual extinction of the vital powers, were in conformity with the course of this disease; with no *post-mortem* examination to verify the diagnosis, it can only be surmised that the dura mater and arachnoid covering the upper convex surface of the right cerebral hemisphere was the seat of the inflammation. The injection of Pilocarpine was transitory in its effects, with no permanent benefit.

Edward T.'s case, likewise presented an unknown origin, but not of a traumatic nature. The meningeal inflammation, instead of producing excitement increased ideation, as in the former ease, caused a mental depression somewhat akin to acute melancholia. Both drugs, food and stimulants were unable to retard the rapid emaciation which closed the scene in this case. A resemblance to typhoid fever prevented the confirmation of the diagnosis, until the rose rash, diarrhoea, and the typhoidal variation of temperature were found to be absent.

BURNS AND SCALDS.

BY JOHN REID, M.A., M.D. ET CH.M., ABERD.

It matters little, so far as this paper is concerned, whether burns are divided into four or six classes; it is of much more importance in estimating the value of various kinds of treatment, to classify according to the locality of the injury. At the outset, I will exclude from notice internal injuries, but as my paper does not claim to be exhaustive, this is perhaps superfluous. My aim is chiefly to examine the subject from a therapeutical point of view, and in order to attain this end it is necessary to examine its nature. The intense excitement of the skin nerves is said to be sufficient to cause death by shock. Golz and others lay great stress on paralysis of the vasomotor skin nerves, and consecutive enlargement of the blood stream, arising from deficient blood pressure, when, by insufficient heart action, stasis of circulation and death result. The removal of skin may lead to the loss of heat, and so death may result. (In one case of scalding the father reported to me that some time before death it was impossible to keep the child warm.) Abeyance of function of the skin as an excretory organ is mentioned. Schulze and Rollet's observations of division and death of the blood corpuscles at a temperature of 45° C. (113° Fh.); their destruction in this way according to Ponfick; further, the coagulation of the blood and muscle fibrin; and finally the absorption of septic material into the circulation, are given as factors in the production of death. It is noteworthy, that in fatal cases, inflammation and embolism of internal organs, especially of the lungs and brains may occur. Note, also, that the effects of intense cold are somewhat similar to those of heat. Foa, from experiments, comes to the conclusion that death arises not through progressive vascular paralysis, but through self-intoxication with fibrinogen substance, which arises in the course of the destruction of the blood through the heat. Whence, when death arises in the course of a few hours, there is firm clot in the heart, and the blood is dark and thickened, ecchymoses and haemorrhagic erosions occur in the stomach and bowel mucous membranes, also congestions of the liver and kidneys. If death occurred in a few days, the blood was dark, follicular enteritis, ulcerated duodenum, speedy emaciation, and special changes in the spinal cord took place; this consists in an entire disappearance of the fat and nucleated red blood corpuscles, shrivelling and turbidity of the nuclei of the cells of the spinal cord, which appear to be filled with intercellular fibrinous substance. According to Foa, the self-intoxication with fibrinous substance, contra-indicates transfusion of blood

or serum. Hayem observed increase of fibre threads characteristic of inflammatory blood, and finds the same in the suppuration stage of variola, desquamation of measles and scarlet fever, absent in uncomplicated typhus and intermittent fevers. He also found haemato blasts bound together by fine granular substance.

Tapeiner records four cases of burning of the second degree, with in one case small quantities of urinary pigment in the blood, in the other negative results. The blood was thickened from loss of serum, but the plasma was normal. He compares the state to cholera, and uses transfusion of serous fluid. Hoppe Seyler mentions cases in which 5% and 2·4% respectively of the haemoglobin of the blood passed into the serum. The blood corpuscles were not markedly altered. The blood on exposure to the air was clear red, and gave a rich oxygen reaction. Methaemoglobin, corresponding to 2·14 grammes of blood, occurred in the urine, not appreciable. Burning by gunpowder is a special burn, with rich pigmentary deposit, and requires no special mention. Catiano says prussic acid is formed in the case of burns, by the decomposition of formate of ammonium into water and this acid, and so he advises to wash the wounds with water, and to give atropin for the heart. In 1881, Gauthier showed the effects of leucomaines in kidney disease, and when the kidneys and skin did not act well; five new crystallised alkaloids were extracted from muscular juice of large animals, acting with more or less energy on the nerve centres, causing sleep, fatigue, and in some instances vomiting and action of the bowels, but less active than ptomaines, but $\frac{1}{4}$ of products of animal combustion are produced in air c. f. acetification. I must, for the sake of shedding light on the pathology of burns, quote Newmann on the pathology of measles and scarlet fever. In measles, on the vessel walls in the upper part of the corium, occurs round-cell proliferation, which follows the vascular loops into the thick parts, even the papillæ. The vessels are dilated and hyperemic. In the sweat glands and external to their walls, as well in the gland dilatation as in the channel, there are thickly placed round cells. The sebaceous glands are also changed. The arrectores pilorum contain between the muscle bundles, round cells. At the insertion of the muscle, the shut in hair bulb has a club shaped expansion throughout its whole extent, due to round cell proliferation. In scarlatina, the rete cells, and especially their nuclei are swollen. The inferior cells are often lengthened, spindle-shaped so as to form gaps and interspaces, in which round cells and blood extravasations are found. The round cells here and there replace the epidermis and even break through the stratum

corneum ; round the exit channels of the skin follicles they are especially thickly placed. The cutis tissue is swollen, its fasciculi pressed upon each other at times from proliferation, at other times from enormously distended vessels, which are widened like ampullæ, and in the enlarged papillæ can scarcely be recognised as loops. I will quote from Travers on irritation, he writes, "A patient in a case of fatal burn, after the first expressions of anguish have subsided, nearly resembles a person stunned by a fall, or as much as possible stupefied with liquor, without suffering an actual suspension of his senses. Inspection demonstrates fulness of the veins of the brain and its membranes, and effusion beneath the arachnoid membrane, confirming the symptoms occurring in the latter stage."

I have now given a pretty full account of the ideas hitherto coming before the profession, if they are small ideas in immense language it is not my fault, but the fashion of the time. How then is this tangled web to be unravelled ? I have purposely given an account of the pathology of scarlet fever and measles, in order to show how useless the skin must be in those diseases, and yet it is a well known fact that when scarlet fever is localised to the tonsil, as in malignant cases, it is almost invariably fatal. To give an account of local injuries extending over a small surface and proving fatal would be tedious, as they are already well known. The increase of fibrin in the blood, and other such things, are too often found in recoverable diseases to be considered as necessary causes of death; for in septic fever it may cause death by spontaneous coagulation (Landois and Stirling, p. 47), and is found increased in other diseases. The production of hydrocyanic acid is mentioned—surely the flame which suffices to produce the gas would be sufficient to burn it. I am not aware that any sufferers have succumbed to the effects of prussic acid poisoning, and if we judge from the pain, I fear we shall have to give this the go-by. We have the facts to refer to—we have the inflamed intestinal canal, the brain affections and haemorrhages late in the disease. If we look on the intestinal canal as skin modified for special purposes, the sympathetic relationship will bear a simpler construction. Do we not find in a sudden chill, the intestinal canal so affected as to be intolerant of food ? Embolism as causing death cannot be gainsaid, but it is not a universal cause. Of course, although I write against certain assigned causes, I do so against their being essential causes, for I am aware that death may result from a multiplicity of causes, any one of which may occur in the course of the accidents we are considering. Tapeiner is not so rash as to argue that the loss of haemoglobin causes death, or even

the loss of blood primarily. For my own part, considering everything, I am inclined to take my key-note from a statement of G. H. Lewis (*Physical Basis of Life and Mind?*) to the effect that water at 105° may be applied topically, but when the body is suddenly plunged into it, there result scathing effects. Take this along with the excessive irritation, and our clinical facts (which, by the way, must always represent the true physiology of the human body) bearing upon burns of varying extent, and I think our clue is evident. So far as I am aware, there are no microscopic observations of peripheral nerves, and I can scarcely be blamed for hinting my belief that they would probably in some cases at least give evidence of inflammatory action in cases of burns and scalds.

Now, regarding treatment, this is the vital point. In a death from scald in a child of two years, I thought I had obtained the secret of treatment. In this case carbolic oil was used, with a mixture in twelve hours containing ammonia and diffusible stimulants (ammonia prevents coagulation of the blood). At 11 a.m., some time after getting first dose of medicine, she vomited vegetable soup, oranges, beef, &c., quite unacted on by the gastric juice. Soda and brandy was ordered, and vomiting soon ceased ; at 4 p.m. the pulse was stronger, but death took place at 6 a.m. on the following day. I attributed death to the constant changing of dressings up to 11 a.m., unfortunately indulged in by an over-anxious mother, and to heart failure. So in a second case, I followed the advice of my senior, wrapped the child in cotton wool, after caron oil had been previously applied by the parents ; gave mixture containing digitalis, ordered milk and soda or lime water. The boy was but nineteen months old, and although a fire was burning in the room, the father reported that death occurred at 1.40 a.m., preceded by convulsions, and that it was impossible for him to keep the body warm, and this, too, notwithstanding the child's falling asleep soon after being wrapped in the dressings. Drumine was then in its weed undiscovered. What a boon to the little sufferers would have been the result of its application !! Carbolic acid at first irritates and then acts as an anaesthetic, so do cocaine, &c. ; besides these drugs are dangerous in their constitutional effects. One cannot but ask oneself " did the patient die of the disease or of the remedy ? " Well, carbolic is a disinfectant, but the uselessness of the oil in that capacity is shown by Dr. Elliston (*British Medical Journal*, Oct. 1886, p. 809), and borne out by experience, (witness carbolic oil dressings which have been applied over twenty-four hours). R. T. Morris opens the burns and applies iodoform, another poisonous remedy if used over a large surface. I have used it with satisfaction in the case of small

burns. It is a well-known fact that caustics form chemical compounds with diseased tissues, which, in cases where the healing process is slow, serve to hide pus, and this is the case with burns, this risk, as medical attendants we are called upon to obviate. Frequently a touch with nitrate of silver brings great credit to a surgeon, but it may also bring him into disrepute. To illustrate my meaning, I will liken the healing or formative process in burns to that which occurs in tubercle, and quote from Creighton to show the state of matters. "The blood vessels are, generally speaking, new formations as in granulation tissue, and the giant cells are, as it were, the imperfect developments of them extending more into the interior of the nodules, and they are the signs of failure in the complete vascularisation of the new formed tissue." Were not this the case with burns, and the drain on the system excessive as a consequence of it, I should in every case favor the production of new tissue with warm moist heat. Let any one, however, consider the drain, and "subjective drawing effects of patients" when poultices are applied over large surfaces in the case of burns, and I think he will admit that this treatment is not the most advisable, although it is very kindly to inflamed nerves. What then are the rational principles of treatment? Locally, soothe the irritation by applications of aqueous drumine, in order to lessen shock, nerve effects, &c. (I speak from experience). In the case of dependent parts of the body, suspend them or otherwise obviate friction. I should, however, have noted that vesicles should be cut open, and loose dead flesh removed. If the skin is charred, it will not absorb, and so subcutaneous injection may be used if considered advisable. Having now placed our wounds in the most favorable state, we must endeavour to obtain healing by dry desquamation (generally double desquamation), which produces the minimum drain on the system. This is done by seeing that oxide of zinc or other neutral powder (not starch, which forms a cast protecting the burn and imprisoning matter) is applied, and that no matter at any time is imprisoned which might induce embolism, &c. The local wants having now been attended to, what is to be done with the intestinal canal? The indications here are to soothe and promote digestion. A dose of drumine or morphia will fulfil the former, and effervescing quinine, the latter (see *A. M. Gazette*) in small doses, frequently repeated with milk. The soda is a sedative, it hinders coagulation of the blood, prolongs the contractile power of muscle. Quinine, twenty grains to the half-pint, dissolved in eight drachms (480 grains) of citric acid, and taken at intervals of three hours, with a corresponding quantity of soda and milk promotes digestion,

but can scarcely be said in these doses to have much effect on the hyperæmia of the brain or reflex irritability of the cord. According to Landois and Stirling (pp. 3, 21 and 22), the red blood corpuscles are increased in size, the number of the white corpuscles is also increased by quinine. I can speak favorably from a clinical point of view. Later on, however, the astringent effects of iron are good. The action of quinine is also antiseptic, and so low organisms in an intestinal canal, decidedly weak if not inflamed, is obviated. It is better not to hasten the return to solid food, as egg and milk are very nutritious and safe. Regarding alcohol, I can but say with Travers, "Sleep will save where alcohol destroys," and opium "in small doses it is inefficacious, and in large ones, injurious." He gives lime water and milk, and uses turpentine and oil if there is much suppuration. This is not required in the dry method. There is another point with reference to the intestinal canal—viz., when should the bowels be opened? I again draw upon Travers, "Purgative medicine ought not to be given until the circulation is restored and pretty steady after collapse." With effervescing quinine and milk or egg, I find a few days cause no inconvenience, a gentle purgative may then be given. Why should it? Surgeons will inform us what they do after some operations in order to keep the bowels inoperative. The kidney and urinary troubles will certainly yield to the dietary; in the case of retention, proper treatment will have to be adopted. I have seen a case complicated with hysteria. This is very puzzling, but cannabis indica, and physostigmina acted well, bromide soon lost its power. As convalescence advances, this is less troublesome. I accounted for the hysterical phenomena by whooping cough of some months duration, preceding the burns. In 1882 I saw a case of scalding (or burning?) after it had been treated for six weeks and confined to one arm, prove fatal by haemorrhage. I have seen haemorrhage occur in an extremity after fourteen days, by putting the feet on the ground. These occurred with oleaginous dressings, but still I think they indicate the absolute necessity for caution. It is better to be sure than sorry, as the old proverb says, and throughout all the stages of treatment this holds good. I have even adopted the liquid treatment for over fourteen days, no other food being tolerated. Internal scalds, by drinking warm fluids, must be treated on the same general principles—*mutatis mutandis*, of course the parts cannot be treated on the dry principles, and nutrient enemata may be called for. I have never seen severe cases—saving of irritant poisoning, and these are beyond the scope of this paper.

THE MORAL ASPECT OF TRAVELLING
REFEREESHIPS.

By A VICTIM.

HE is a new chum medico, most frequently from the green Isle or bonnie Scotland, with little of life's experience or wisdom. The wild and exaggerated ideas he has formed of a rapid fortune and a speedy return, with substantial glory to his native heath, soon receive a check. He finds here more difficulties than at home, where frequently his father's business connections would have helped him, at least to a fair and honorable living, if not to wealth. To what must he turn? Assistants are seldom kept, no dispensary appointments, and all Hospital or Government appointments depend not on the qualifications of the applicants, but on their influence. The die is cast. He sees the tempting advertisement of "The Firework Figures Assurance Society," and is entrapped. The "Reliable" manager offers him £3 a week travelling expenses, and a guarantee of four cases (£4 1s.) a week, and with his usual suavity, assures the confiding new chum, he is certain to do ten to fourteen cases a week. The medico's hopes revive, for this to the *uninitiated* promised future riches. He starts on his perilous career. Steamer to Newcastle, and a dreary train and coach journey brings him to the meeting place of his agent. He finds the agent rather strange, but inwardly reflects, it may be climatic, and a change of moon will bring a better state of his travelling companion's health. Soon however, the truth dawns upon him. The agent is on the "bust." What is he to do? The small advance given him by the "Reliable" manager against his allowance and guarantee, has gone in reaching the agent. He writes the "Reliable" manager, and is told to remain till the agent is ready, and he lives on the promise of a future cheque. Alone—lonely—wretched and friendless, surrounded by men of coarse and drunken habits, he follows their example, and drinks. At first it is distasteful to him, since the vile compounds sold in New South Wales as liquors are as filthy to a sound palate as they are destructive to body and soul. The "spree" is over. They start; but the young medico's moral and nervous force has received the first shock. Sometimes successful in getting cases, oftener going for days without, under a tropical sun, with bad food, unclean and lively beds, for which he pays the blood-sucking publican 10s. per day, nature exhausted, suggests more "fire" water; it is taken, and what but a few months before he would have shuddered at, now becomes a fixed habit. He can no longer do without strong drink. Further and further back he travels, till the acme of unhappiness is reached—a back block township. One bad habit confirmed, there are yet others to follow in its wake. No longer under civilising or homely influences, his manners, from "familiarity" with inferiors, become loose and ungentlemanly. He dresses carelessly, and the dirty grogshanties he has to stay at, without baths, and often water, afford him an excuse for uncleanness. By degrees the consummation is complete. He is unfitted for private practice, and must continue this degrading occupation, since he has lost whatever knowledge he had of medicine or surgery, having neither the opportunity of practice or desire of reading. The mind becomes moribund and all energy departs, these vile habits increasing, accident, suicide, or drink ends the lot of a mother's love and a father's hope. I do not wish to imply this is always the case, though it is often so, and no one can deny the immoral influences towards this unhappy result. Of course there are strong-minded men who can pass through this sad career

unhurt, but they are the few. For the travelling referee there is little reward; whilst the agent gets £1 per hundred up to five hundred, when he has £1 5s., and for each thousand case £1 10s. per hundred, the doctor receives only £1 1s. a case be the amount ever so great or the work exhausting. If an agent take three cases a week of one thousand each and the applicant pays yearly, he would be paid £45 commission, the doctor £3 3s. The "Reliable" manager has from £900 to £2000 a year, sitting in a cool room and criticising the agent and doctor, with an occasional trip to Europe, at the expense of the unsuspecting policy-holders, who also pay his substitute. In conclusion I warn my brethren against having anything to do with these travelling appointments for the sake of their own reputation and the honor of a noble profession.

PROCEEDINGS OF SOCIETIES.

QUEENSLAND MEDICAL SOCIETY.

THE ordinary monthly meeting of the above Society was held in the School of Arts, on Tuesday, April 12. There were present: Drs. Bancroft (in the chair), Campbell, Taylor, Little, E. H. Byrne, W. S. Byrne, C. F. Marks, Thomson, Hare, Hogg, Gibson and Love. Drs. Flood and Thorpe were present as visitors.

EXHIBITS.

Dr. Hogg, of Goodna, shewed—

(1). An aneurism of the transverse arch of the aorta pressing backwards upon the trachea, which had undergone spontaneous cure.

(2). A heart shewing much atheroma of the aorta, with complete occlusion of the left coronary artery and great diminution in the calibre of the right artery. It was taken from a case of general paralysis, the patient had tried to escape, when he was seized with an attack of fatal syncope. There had been no anginous attacks.

Dr. Bancroft exhibited a specimen of the Alstonia bitter bark, which he had been in the habit of using as a bitter.

Dr. Gibson shewed the trachea of a child who had died from diphtheria. There had been no patches upon the fauces or pharynx till the day before death, when a small speck or two appeared upon the soft palate. There was a complete cast of the trachea in membrane, which probably, also extended down lower into the bronchi. Tracheotomy had been performed with but little relief.

Dr. Bancroft distributed some copies of his pamphlet on "Contributions to Pharmacy, Queensland," which had been written for the Colonial and Indian Exhibition.

TYPHOID FEVER.

Dr. HARE was then invited to give his reply to the discussion on his paper on typhoid. He said:—

"Concerning the treatment of typhoid, it seems to me that the general principles of nursing, diet, etc., are fairly well established. The most important question in the present state of medical knowledge, is to decide whether we are justified in allowing the pyrexia to run its course unchecked, or whether we should not rather systematically reduce it, either by drugs or quinine, or by the application of cold externally. I am sorry I have not enough experience to speak confidently about the bath, but from what I have seen, it certainly merits a trial that, as yet, it has never had in this country."

That simple continued fever and abortive typhoid as seen in Brisbane are merely modifications of enteric fever I feel confident, for (1) they frequently come

from the same house, where they are presumably due to the same causes, and it is not rare to see all three forms in the same family. Again (2) abortive cases and cases of S. C. F. are frequently followed by relapses, which present all the clinical and pathological features of typical enteric. Dr. Little has said that he looks with more suspicion upon cases which have an insidious onset, than in those where the disease sets in suddenly. My experience certainly confirms this. Cases which begin suddenly, without any previous feeling of slight malaise, and especially when the patient is able to say the hour he was taken ill, most frequently abort—there are of course some exceptions to this. To the opposite, however, there are very few exceptions indeed; that cases commencing insidiously are severe, that is to say, prolonged.

If one attack of typhoid confers immunity from future attacks, I am greatly mistaken—I have seen one patient who has had it three times in eighteen months, and another case came into hospital last month with perforation, who had almost succumbed to a severe attack of enteric fever two years ago. In this case there were only two ulcers in the ileum, and no trace of Peyer's patches could be found for some distance from the valve. It has often occurred to me that one attack actually predisposes to a second; and this is most certainly true if we regard a relapse as a second attack. I have no theory as to the nature or origin of relapses, but the fact that they frequently occur after a fortnight's convalescence or later, shows that the primary attack had certainly afforded no protection to the constitution. I have kept no record of the frequency of spots, except in the last thirty cases discharged; of these twenty had them undoubtedly, and in ten none were seen, but of these ten, five aborted early and one was convalescent on admission. The other four may have had them on the back, but certainly had none on the anterior aspect of the body. I look on them as confirmatory of the diagnosis, but should never think of making them an essential.

With regard to the infectiousness of the disease, I have never seen anything to support the theory that it is so, in the ordinary sense of the word, although I am quite prepared to agree with Dr. Bancroft that it may be so in rare cases. Last year a number of cases occurred among the nurses, but those in the fever wards were not attacked in greater proportion than those in the general wards, and the outbreak was, to my mind, satisfactorily explained by the insanitary condition of the water closets adjoining the sleeping apartments. Since the nuisance has been removed, there has been but one case among the nursing staff, and there is good reason to think that this was contracted at her father's cottage, in a neighbouring swamp, whither she was in the habit of going every night.

That the stools of typhoid patients, after a certain period, are capable of reproducing the disease, I regard as an established fact, and I believe most cases are infected from this source, but whether the poison can be manufactured anew from filth of various descriptions, I think must still remain an open question; at any rate it seems to me that the causes of the disease in Brisbane are essentially the same as in Europe, and can therefore be met by the same sanitary measures.

Dr. BANCROFT said, with regard to the treatment by cold, he would like to see a hospital ward kept cool by a Bell and Coleman's refrigerator, for the treatment of typhoid and other febrile diseases. At one time at the Brisbane Hospital much fear was entertained of patients taking pneumonia from the exposure treatment. He had very little fear of the effects of draughts of air in such cases, and to test the matter had three cases of typhoid kept under the open windows

all the severe period of their fever; none of these cases took pneumonia and seemed all the better for the fresh air treatment. He did not think the pneumonia of typhoid was caused in this warm country by breathing cold air.

DISCUSSION ON DIPHTHERIA.

Dr. LOVE then introduced a discussion upon the treatment of Diphtheria, by reading the notes of a case in which he had lately performed tracheotomy with a successful result. He remarked that the disease had been unusually rife in Brisbane during the late wet season, but that it was by no means an uncommon disease—in fact it might fairly be considered endemic. In the year 1873 there had been 73 deaths registered in the colony as due to diphtheria, while in 1885 the number was 87. Last year in Brisbane there had been 19 deaths registered as due to diphtheria, while already in 1887 there were 13. These numbers were, however, rendered nearly valueless, save from a minimal point of view, by the fact that many practitioners filled in their certificates with the term "diphtheritic croup," and such cases were registered as "croup." During the five years 1881-5 there had been 483 deaths in the colony due to "croup." So that in consequence of the schism among medical men as to the true relationship of croup and diphtheria, no approximation as to the frequency of diphtheria could be made.

He did not intend to enter into any critical exposition of the current views upon the subject, but merely intended to introduce discussion and invite the convictions which experience and theory had led each to adopt for himself. The case to which he referred before was that of a boy, $\text{st}. 4$ years, who was admitted into the Hospital for Sick Children on the 20th January last. He was very flushed and restless—temperature, 99.4° ; pulse, 126; rest, 28. There was copious deposit upon both tonsils and soft palate, with a dull port-wine-colored area of passive congestion; urine with a trace of albumen. The little patient was put into a side ward, and a tent erected over his bed, with steam impregnated with lactic acid playing into it. The throat was brushed with acid lactic dil. every four hours, and, in the intervals, a handspray of lactic acid (1 to 10) was used. Internally—beeftea, eggdip, brandy occasionally, and a mixture containing 10 m. of perchloride of iron tincture and chlorate of potash. Next day the child was about the same—a little more albumen in his urine. He took his food well, and made a capital little patient, opening his mouth readily for the brush and the spray.

The following day he appeared much worse, however—restlessness greater, pulse quicker, and though the fauces were cleaning, the mischief was evidently spreading down into the larynx, as the breathing was more noisy, and he often put his hand to his throat as if to clutch it. By the afternoon his condition had become decidedly worse—there was evident obstruction of the larynx, his face had become more cyanotic, and there was marked retraction of the supracleavicular and suprasternal spaces and of the epigastrium. He decided to do tracheotomy without delay. The operation calls for little comment—the high operation being chosen. A reflex fit of coughing was set up by passing a pipe-cleaner brush (previously disinfected) down the trachea. The brush brought away a large piece of membrane, a couple of inches long, and further cough brought away more—shewing that the disease had extended into the trachea. The operation was soon followed by complete relief—the child slept well that night, his breathing being soft and regular. After this, he improved steadily from day to day—his throat, which was still painted and sprayed gradually cleaned,

and the discharge from the tube became less. The inner tube, which was fenestrated, was removed about twice a day by myself, and as occasion required, by the lady superintendent, who was nursing the case herself. The tube was always washed in lactic acid, and oiled with carbolic oil, before being returned. Occasionally the discharge got very sticky, when this was remedied by a spray of carbonate of soda solution. By the 26th, four days after the operation, the throat had quite cleaned. The wound became diphtheritic for a few days, but the membrane easily removed by lactic acid, and the surface dusted with boracic acid. The tube was removed on the 12th day after the operation, and in 10 days the wound had quite healed. It was nearly three weeks later before he could speak in a loud voice—and he was discharged on March 18th in perfect health. There had been some temporary paralysis of the left 6th nerve, but that had passed off before dismissal.

This, he wished to be regarded as a routine case of the disease in which, however, the respiratory tract was involved. The indications for treatment in general he considered were twofold, constitutional and local, just as the dangers were twofold, viz.: from septicæmia and respiratory obstruction. He had little doubt as to the constitutional nature of the disease—the characteristic membrane being merely the local manifestation of the constitutional infection, just as the inflammation of Peyer's patches was a consequence, not a cause of typhoid fever. He supposed few diseases had had so many "remedies" applied—and each man was wont to vaunt his own as little short of specific.

For an ordinary routine case, the cardinal point was proper feeding and general support of strength. Next, the administration of some blood-tonic and antiseptic, such as perchloride of iron in large doses, with say, chlorate of potash, was a generally accepted line of treatment, and a good one. Locally the great aim was to prevent the extension of the deposit to the air-passages proper, and for this end all the antiseptics had been tried in turn with varying success. As in the case narrated above he was in the habit of using lactic acid, and for two reasons—primarily because it had a distinct solvent action upon the membrane, and secondarily for its undoubted germicidal properties. Anyone who had seen section of the swollen submaxillary and parilyngeal glands, would remember how the alveoli of those glands were literally stuffed with micrococci, and though the membrane was in all probability of the character of a lowly-organised inflammatory product, still the general constitutional effects were very largely due to the presence of these organisms in the blood-patha. The solvent action of lactic acid he considered undoubted. Some flakes of membrane were put into a bottle containing dilute lactic acid, and next morning they were found quite disintegrated, and the fluid had become milky. There were many other substances which probably possessed equal solvent powers with lactic acid, but it had the antiseptic property in addition to render it suitable. Of course in each individual case, symptoms would arise calling for special treatment. It was a curious fact how the nasal form of the disease was the form *par excellence* in which septicæmia was most liable to occur, and for that he had used alternate injections of carbolic acid lotion (1 to 80) and lactic acid.

Lastly, in that form where the disease had reached the air passages, where the signs of respiratory embarrassment were becoming more and more typical—the breathing stridulous and laboured, and the soft parts of the chest receding with every inspiration—then comes the question of tracheotomy. He believed the reason why it had been so unsuccessful in diphtheria was due to one of two reasons—either it was looked upon as an

ultima ratio, and delayed as long as possible, or else the operation was looked upon by some as a means of cure rather than as a relief for an urgent symptom, and consequently after treatment was not sufficiently attended to. If every medical man were to look upon timely tracheotomy as the rational treatment for the laryngeal form of the disease, far more successes would be recorded. The refusal of the parents' consent was often an obstacle, but if the possibility of its necessity were often and earlier urged, the popular prejudice would gradually abate before the larger number of successful cases. Of course it was of the first importance to discriminate between cases in which tracheotomy might be expected to succeed and those in which no permanent benefit could be anticipated from the operation. Dr. George Buchanan, of Glasgow, had pointed out that in cases where the air passages below the point of obstruction were free, and the lungs were in a normal condition, there was a great recession of all the soft parts of the chest. At each inspiration the intercostal spaces fell deeply in, and the epigastrum formed a deep hollow. If, on the contrary, the smaller bronchial tubes were full of mucus or diphtheritic exudation, the movements of the chest-wall were impeded, and the chest was puffed out so as to resemble the distended thorax of emphysema.

Finally, they should remember Edmund Owens' dictum, "If there be a doubt as to whether the operation may not be still further delayed, it will generally be better to perform it forthwith—many a case is lost from tracheotomy being delayed." With these sentiments he thoroughly agreed, so far as his experience led him. He had operated upon three occasions, with two successes, and he was convinced now that to the delay in operating in the other case was due the untoward result. With these necessarily brief and perhaps dogmatic expressions of opinion he would close, and hoped to benefit by the larger and more varied experience of some of the members present.

Dr. W. S. BYRNE said he was glad of the discussion, for his had not been a happy experience in diphtheria. He had had forty cases in nine years, and he could count the recoveries on his fingers. He congratulated Dr. Love on the success of his case. He had in his hand a record of 142 cases, compiled by Drs. Gee, Dickinson, and Fagge. These were divided into three sets. (1). Those in which no membrane was seen or coughed up during life. (2). Those in which membrane was seen during life in pharynx or larynx. (3). Those in which membrane was limited to tonsils and soft palate. The following table gives the numbers with the results:—

(1). No membrane seen.

	Cases.	Recoveries.	Deaths.	Tracheotomies.
Dr. Gee ...	13	13	0	0
Dr. Dickinson	14	13	1	0
Dr. Fagge ...	11	9	2	7
	38	35	3	7

(2). Membranes seen during life in pharynx or larynx.

Dr. Gee ...	25	2	23	15
Dr. Dickinson	23	6	17	18
Dr. Fagge ...	42	1	41	24
	90	9	81	57

(3). Membranes on tonsils or fauces, without implication of air passages.

Cases 14. Recoveries 12. Deaths 2.

Average length of membranous laryngitis or diphtheria—35 days. The fatal cases were all verified on *post-mortem* examination. In the first set, the *P.M.* appearances were œdema of the glottis and first five rings of trachea and bronchitis, exudation of mucus in others.

The term "croup," he found was used with widely different and often indefinite meaning, for laryngism stridulus, membranous laryngitis, laryngitis, oedema glottidis, etc. Was there a definite clinical difference between diphtheria and membranous laryngitis? Dr. W. Reed had described a case where a lady had fainted and a too zealous friend in his confusion had poured some eau-de-Cologne down her nose; inflammation of the air-tract supervened with all the physical signs of diphtheria, and the patient coughed up a cast of the trachea in membrane, a couple of days later; that was a case of membranous laryngitis proper. There had been cases recorded at Guy's Hospital where membranous exudation followed scalds, and cut throats. Clinically speaking, however, membranous laryngitis and diphtheria he considered synonymous terms. There was a form of non-membranous laryngitis with all the symptoms of diphtheria. When there have been patches, his patients have mostly died.

Dr. LITTLE said that in practice he felt quite satisfied that there were three chief forms of throat affection that they were called to deal with. When called up in the night to see a child, and he found it feverish, with husky breathing, but with no sign of membranes, he considered that a case of laryngitis pure and simple, calling for steam-kettle, calomel and aconite. Again, there was the true diphtheria with membrane; and lastly, an intermediate disease, where there was no membrane, and the breathing was not husky but crowing, this last he called spasmodic croup, and found it relieved by an emetic. As to the treatment of diphtheria, he did not approve of tearing away the membrane, for some of it might easily be dislodged and get into the air passages and set up fresh formation of membrane there. He had had a successful case which was treated with lactic acid, and again, on the other hand, he had had cases in which lactic acid was of no benefit.

Dr. LOCKHART GIBSON said that it was most important to decide on the best method of treating diphtheria, and that the treatment employed would necessarily vary with the view taken of the nature of the disease. For his own part he saw strong reasons for agreeing with the opinion advanced by Gerhardt, and supported by Stoerk and others, viz.:—that the mortality due to the disease may be reduced to a minimum if the cases are seen early, and the diphtheritic membrane is constantly removed. He said, Stoerk brushes off the membrane with a hard brush, and then pencils the site with a saturated solution of nitrate of silver sufficient to make an eschar, and claims to prevent fatalities if he sees the cases early enough. He considers that diphtheria always begins in the pharynx and that the so-called membranous croup is really diphtheria in the larynx, and secondary to the affection in the pharynx. And this opinion that diphtheria and membranous croup are one and the same disease is rapidly gaining ground. For my part I hold it very strongly, though I do not think it at all impossible for diphtheria to commence in the lower air passages. However, as I believe, since the infecting material is inhaled, the upper air passages are naturally most frequently affected.

I have little doubt that there are special conditions of the system which make it a fitting nidus for the diphtheritic poison, but I believe very strongly that the commencement of the disease is really local—viz.: the diphtheritic membrane appears in some part of the air passages. As its appearance is not accompanied by much pain or uneasiness, it is often not recognised until it has been there for a day or two. After which, the system generally begins to show that it is absorbing the poison. It is only within the last eighteen months

that I have become thoroughly impressed with the fact that, if the diphtheritic membrane is seen early enough, and is removed by forceps, or a rough brush, and its site thoroughly soaked with a strong antiseptic, and removed at least twice daily in the same way, until it ceases to recur, the system does not become infected to any marked extent. I have only had three cases in which I have carried out these principles in their entirety. In each of the three cases there were patches in the pharynx. In one, a patch on the posterior surface of the epiglottis, and, in the other, two extensive deposits of thick leathery membrane on the pharynx, tonsils, soft palate, and uvula. Within a few hours of the removal of the membrane, the temperature, which varied in all three from 100° to 101°, sank to 99°, and then to normal, the pulse from 120 to 80, and the look and feeling of depression disappeared. In two of these cases I had to brush off the membrane twice daily for three weeks, before it entirely disappeared, but I was rewarded by the almost total absence of any depression of strength throughout the whole course. The other case got well within a week. I used lactic acid for anointing the brush, and caused a spray of lactic acid to be inhaled every two hours, night and day. In two cases I gave tinct. iodin. by the mouth, and in my last case 15 to 20 min. doses of tinct. fer. perchlor, eighteen times daily for some days, without disordering the bowels or interfering with a splendid appetite. In my last case, I caused a gargle to be used every two hours, of a solution of Buyer's liquor pancreaticus, made alkaline by carbonate of soda, and heated to 100° Fah., and for the last ten days I used the undiluted liquor pancreaticus made alkaline by carbonate of soda, for brushing the patches with. It has, undoubtedly, the property of dissolving the membrane, I think more than lactic acid. Cases recorded as diphtheria without any membrane, are, in my opinion, either not cases of diphtheria, or cases where, owing to want of laryngoscopic, or want of *post-mortem* examination, the membrane has not been discovered.

Dr. THOMSON said that he had met with some cases of diphtheria which ran a more lengthened course than the ordinary form. There was also another variety where there was high fever, fast pulse, an angry throat, with ragged yellowish patches of thick lymph on the surface, like the ragged patches of a typhoid ulcer. This form he could always prophecy would get quite well in four or five days, the treatment adopted being a hot bath, a calomel purge, Condy gargle and an iron mixture. He had been at a loss what to call this till he saw it described in a Canadian Medical Journal as croupous tonsillitis. He had found it infectious, in that one case in a family was usually followed by others. He did not think it of a diphtheritic nature. His experience of tracheotomy in diphtheria had been very unfortunate—he had operated ten or twelve times with no success. If he remembered rightly, the statistics given by the Committee of the British Medical Association as to results of tracheotomy for diphtheria gave only 5 per cent. of successes. He wished to know particularly (1) What are the media of infection? (2) When may a child be considered to be out of quarantine?

Dr. TAYLOR was very much interested in the causation of the disease, attacking, as it did, the rich and poor, clean and dirty alike. Its origin was often attributed to sewer gas. In a recent *Practitioner* the subject of disposal of house refuse was gone into as affording a cause. In the house bins, both animal and vegetable matter, festering together, brought about the malady. He quoted several instances from the paper mentioned shewing how cases had occurred after the mixture of animal and vegetable matter, though not

occurring while the heaps were separate. Cases of croup, he said, often ran their nightly course for three nights, and then the diphtheria appeared. He had seen children with sore throats, but with no membrane visible, and yet these children got diphtheria in the larynx and died. The cases of croupous tonsillitis he considered diphtheritic and, if allowed to go on, would kill. His own child had been somewhat out of sorts and bled at the nose several times, but never complained of any difficulty of swallowing, and yet, on examination, there were two large patches on the tonsils—the child recovered. He himself had had croupous tonsillitis on both tonsils successively. Every case of membranous laryngitis he considered diphtheritic. He had been very unfortunate in the treatment of his cases of diphtheria till three years ago, when he used perchloride of iron in large doses, 15-30m of the liquid every hour. Tracheotomy was very often unsuccessful, owing to the delay—it was too much looked upon as a method of cure instead of an assistance.

As to the question of solvents, he had no experience with lactic acid. Then there was the juice of the Papaw tree—the so-called Papain—that, he considered, should be useful, as meat hung under the tree soon got tender. Alluding to an experimental research by Renshaw in the *Practitioner*, he said that the experiments adduced showed marked differences in the virulence of the poison in croup and diphtheria. Diphtheritic membrane, administered by the stomach to dogs, or inoculated into a wound, proved very deadly, while that of croup had no effect. Diphtheria he did not consider very contagious. As to the media of infection, the membrane was likely to occur on any mucous surface, and, therefore, he would consider all discharges dangerous. The diphtheria common among fowls and pigeons, and known as "warts," he considered to be true diphtheria, and it perhaps played a larger part in the dissemination of the disease than was believed.

DR. BANCROFT did not believe that the admixture of decaying animal and vegetable matter caused diphtheria, for in the slaughter yards the paunches of the cattle, filled with vegetable, were often allowed to decay, and yet diphtheria was no more prevalent there than elsewhere. He had occasionally noticed it on the tops of hills in winter when the winds were blowing upon Bowen Terrace. He had had many tracheotomies, but with no successes; at any rate they are much relieved and die easily. He used to use powdered nitrate of silver to kill the membrane; then he gave iodoform a fair trial, but found it no use. Latterly he has used tincture of iodine (B.P.) locally and internally. He had not tried lactic acid.

MEETING OF MEDICAL PRACTITIONERS OF SYDNEY AND SUBURBS.

FRIENDLY SOCIETIES AND THEIR MEDICAL ATTENDANTS.

A MEETING of members of the medical profession was held in the Royal Society's Room, Sydney, on Friday May 6, 1887, to take into consideration the relations existing between the Friendly Societies and their medical attendants.

Dr. MACLAURIN took the chair, and there were forty-five members of the profession present. Apologies were received from Drs. Barkas, Jackson, Schwarzbach, T. B. Clune, Dowd, and McKay.

Dr. CLUBBE moved, "That this meeting is of opinion that the present mode of payment of medical men by

the various Friendly Societies is not satisfactory, and needs reform," and said:—It devolves upon me to move the first resolution, which is as follows: "That this meeting is of opinion that the present mode of payment of medical men by the various Friendly Societies is not satisfactory and needs reform." At the last meeting of our branch of the British Medical Association, a similar resolution was assented to, and a committee was appointed to inquire into the matter. This committee, after mature deliberation, decided to call together a meeting of the whole profession, and place before them certain resolutions, with a view to their being discussed and adopted. For many years there has been a wide-spread feeling of dissatisfaction among nearly all medical men who have been connected with Friendly Societies. There has been any amount of growling and grumbling; perhaps when a lodger patient has been more than usually irritating, by sending for his doctor for some extremely trivial ailment, or at some very inopportune moment, the doctor has given vent to his pent-up feelings by the use of some very unparliamentary language, and has anathematized that unfortunate patient in particular, and lodges in general. But "hard words break no bones," and cursing the system is not the way to bring about reform. It is an extraordinary thing that medical men have not, long before this, seen the necessity of united action in matters of this sort, to bring about beneficial changes. We, as a body, are supposed to be educated rather better than the ordinary run of men, and to have a reasonable amount of intelligence and common sense, and yet we allow ourselves to be ridded rough-shod over by a combination of the lower orders. At present they dictate their terms to us, but we ought to dictate our terms to them. Now, what are the chief causes of dissatisfaction? First I think is the inadequate payment for the amount of work performed. Second: That there are so many calls on the doctor when there is no need. The people know that they have not to pay any more whether they see the doctor once or 365 times a year. Thirdly: That very many healthy people and others, not perhaps rich, but who are perfectly well able to pay a doctor his usual fee, do not hesitate to use these lodges to get their medical man to attend them and their whole family for a few shillings a year. These lodges were intended at first for those people who were really not in a position to pay a doctor; but now it is quite the exception and not the rule, to find a really poor person belonging to them. In this city, at the present time, there are medical men attending whole families for 7s. 6d. a year; the average amount they get per member is certainly not more than 15s. Now, why is it that the lodges are tendered for at such absurdly low prices? It is because there is so much competition, and medical men will tout for these lodges, and do not hesitate to undersell one another. We hope, by means of the action we are taking, to bring about a better state of affairs, and shew members of our profession that it is to their own interest to fix a minimum sum for which lodges are to be tendered at. How we are to enforce this is another matter? We can only, I suppose, go to each member individually, and get him to give us his word that he will do his best to maintain the honor of the profession and not tender below a certain fixed rate. If, after a man has given his consent, he breaks his word, he can be tabooed by all respectable medical men. Gentlemen, I will not detain you further; there are many other speakers who have to move resolutions bearing on the matter. What I want to ask you now is this, are you or are you not satisfied with the present system of payment? If you are not, you will not hesitate to give your vote for the resolution which I now have the honor to move.

Dr. SCOT SKIRVING seconded the resolution, which was carried.

Dr. KNAGGS proposed—"That a standard agreement be settled by the profession for all Friendly Societies, and that, as a point of medical ethics, members of the profession in this colony adhere to it"—and said that he (Dr. Knaggs) supposed that he had been asked to move this resolution, as he had had 12 year's experience of work among lodges, which, he could assure gentlemen present, had not been altogether satisfactory.

Dr. ELLIS seconded the resolution, which was carried. A draft agreement was submitted for the consideration of the members.

Dr. QUAIFE moved—"That it is desirable to know which of the following modes of payment commend themselves to the meeting.

(1). Payment by work done. There can be no doubt that it is desirable to come to some determination in this matter, and he (Dr. Quaife) thought that the most satisfactory way to deal with the question, would be for the profession to be paid for the amount of work done. Under the present system, the medical attendant was practically the slave of the lodge patients, and had no legal right to refuse to go and see a patient, although he might have been grossly insulted by the same person just previously.

Dr. CRAGO seconded the resolution, and said that his experience of lodge patients was rather limited; but he thought that the medical attendant should be paid for the work he performed, and that would do away with many of the unnecessary calls that he now receives.

Dr. WORRALL proposed as an amendment. "That the present rate per member be raised, and a minimum fixed."

Dr. POCKLEY seconded this amendment.

Dr. ELLIS proposed a further amendment. "That payment be in the usual way, by a fixed sum for subscribing members, and extra for members of his family." In moving this amendment, Dr. Ellis said, he thought it would be desirable to form a Medical Protection Society, and when any new arrival presents his credentials for registration, he should be induced to join this Society, and throw in his lot with the gentlemen already established here. Dr. Worrall had rather thrown cold water on the whole scheme by saying that there would always be someone who would undersell others, but if any medical man did that kind of thing he would become a marked man. The tendering system was degrading in the extreme, and should be done away with; if it goes on, the price will ultimately come down to 5s. per member per annum, and another matter in connection with this is that there are men in receipt of £3,000 to £4,000 per annum, who use the club doctor without any extra fee; this, in itself, is a disgrace. He (Dr. Ellis), does not think there are any members of the profession who would not subscribe to the agreement, and join such a society.

Dr. KENDALL seconded the amendment.

Dr. HANKINS moved as a further amendment. "That any one of these three modes of payment may be made use of in the various lodges." Although he (Dr. Hankins), had been asked to move this amendment, he was afraid that the plan would not work; they would not be able to do as other societies, and if a man became marked, as suggested by Dr. Ellis, and he had any spirit in him, he would fight the whole profession rather than give in. The tendering system was no doubt a very bad one, and either of the resolutions before the meeting would meet the case; but they must remember that whatever they did must commend itself to the lodges. The main object of a man in joining

these lodges is to get rid of the doctor's bills, and they must keep this idea clearly before them in making any rule. The following plan would commend itself to most people, viz.:—Charge the subscribing member 14s. per annum, and one-halfpenny per week each for his wife and family up to the number of four, this would bring the cost up to an average of about £1 per member per annum.

Dr. KENDALL seconded the amendment.

Dr. CUMMINGS moved, as an amendment, "That the members of the profession do not contract in any form, but charge for all work as usual. The services of the medical man to be paid for by the club at each medical man's usual rates."

Dr. KNAGGS seconded the amendment *pro forma*.

Dr. CARRUTHERS said he quite agreed with Dr. Hankins' remarks. It would be impossible to get payments by results, as the lodges would not enter into an agreement in which there was an unlimited liability. He (Dr. Carruthers) would prefer to have the price raised and a minimum fixed, and if it were understood that members would not meet gentlemen who tendered lower than the minimum, it was almost certain that they would refrain from fighting the profession.

Dr. BROWNLESS said he perfectly agreed with Dr. Carruthers that to fix a minimum would be the only way to get over the difficulty.

Dr. BOWKER said he had not had much experience of lodges; but he thought one fact had been overlooked, and that was that gentlemen often took these lodges with a view of working up a practice by that means. If the lodges are at fault, why are there so many ready to take them at a reduced fee?

Dr. SCOT SKIRVING said, that with regard to payment by results, he thought it was a hopeless case to expect that to come about. Dr. Bowker had said that very often these lodges were taken to work up a practice, but his (Dr. Skirving's) experience was entirely opposed to that idea. A standard agreement should be drawn up, so that all medical men would have a reliable guide. As payment for work done was out of the question, the next best plan would be to raise the price and fix a minimum.

Dr. BELGRAVE was glad that this matter had at last attracted the attention of the medical profession; but as he would have an opportunity to speak more fully on the subject when the report of the committee (referred to below) came on for discussion, he would not detain the meeting now. The whole subject should be dealt with, as there was a great need for reform with regard to the Friendly Societies. A sum of £400,000 (?) was annually subscribed by the members of the various societies, and no adequate information could be obtained as to the disposal of this vast sum.

After a further discussion by Drs. Knaggs, Hankins, Clubbe, Crago, Ellis, Cummings, and O'Neill, the Chairman put the various amendments, with the result that the amendment moved by Dr. Worrall *i.e.* "That the present rate of payment per member be raised and a minimum be fixed," was carried.

Dr. CLARK proposed, and Dr. Brownless seconded:—"That a committee, consisting of Drs. Quaife, Worrall, Kendall, Musket, Crago, Knaggs, Hankins, Brady, Belgrave, Scot Skirving, Ellis, Clubbe, Carruthers, and the mover and seconder, with power to add to their number, be formed for the purpose of settling the proposed changes, and of getting the profession to loyally adhere to them. In moving this resolution, Dr. Clark said that they ought to thank Dr. Clubbe for his disinterestedness in this matter, in taking so much time and trouble over it. There ought to be no difficulty in getting the majority of the medical profession to conform to the agreement, &c., that would be drawn up by

the committee. It had been said that they ought to form a Protection Society, and, no doubt, it would work well; but it would be impossible to do anything without unity. The resolution was carried.

Dr. POCKLEY proposed—"That the above committee have power to consider the question of the formation of a Defence Association."

Seconded by Dr. Goode, and carried.

Dr. KNAGGE proposed—"That a vote of thanks be accorded to Dr. MacLaurin for taking the chair at this meeting." Carried by acclamation.

Dr. MACLAURIN acknowledged the vote, and the meeting terminated.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Noyes, Alexander Wellesley Finch, L.R.C.P. Lond., 1886; L.S.A. Lond., 1886; M.R.C.S. Eng., 1886.
 Norcott, William Boyle, M.R.C.S. Eng., 1848.
 M'Donagh, John Michael, L., 1882, F., 1883, R.C.S., Irel.; M.R.C.P. Lond., 1886; L. Mid. R.C.S., Irel., 1883.
 Wright, Robert, L.R.C.S. Irel., 1882; L.K.Q.C.P. Irel., 1883; L. Mid. R.C.S. Irel., 1883; L. Mid. K.Q.C.P. Irel., 1883.
 Westrum, Wilhelm Adolph, M.D., Munich, 1886; Staat's Examen Certif., Munich, 1886.
 Harney, Thomas Richard Aloysius, M.R.C.S. Eng., 1886; L.S.A. Lond., 1886.

NEW ZEALAND.

Campbell-Wilkinson, Ernest William, L.F.P.S. Glasg. 1884.
 Cunningham, John, M.B. et Ch.M. Edin.

TASMANIA.

Cotterell, William, M., 1882, L. et L. Mid., 1871, R.C.P. Edin.; L.S.A. Lond., 1870.
 Crampton, John Samuel, L.R.C.P. et R.C.S. Edin., 1875.
 Roome, Stanley Molesworth, M.R.C.S. Eng. et L.R.C.P. Edin., 1886.

VICTORIA.

Walter, John Bellett, M.D., Dubl., 1886.
 Gordon, Arthur Henry, M.R.C.S. Eng., 1883; L. et L. Mid. R.C.P. Edin., 1883.
 Ross, Joseph, Staat's Examen, Greifswalde, 1881; M.D. Wurzburg, 1882.
 Macnaught, John, L. et L. Mid. R.C.P. et R.C.S. Edin., 1877.
 Williams, Edward Johnson, L.R.C.P. et R.C.S. Edin., 1886; L. Mid. K.Q.C.P. Irel., 1886.
 Goodall, William Ainslie, L.K.Q.C.P. Irel., 1885; M.D. et Ch.M. Victoria, Canada, 1885; L.C.P.S. Ontario, 1885.
 Heard, Charles de Wolfe, L.R.C.P. et R.C.S. Edin., 1881.
 Fetherston, Richard Herbert Joseph, L.R.C.S. Irel., 1884; L. et L. Mid. K.Q.C.P. Irel., 1885; M.B. et Ch.M. Edin., 1886.
 Scantlebury, George James, L. et L. Mid. R.C.P. et R.C.S. Edin., 1886; L.F.P.S. Glas., 1886.

Additional qualifications registered:—

Anderson, James, L. Mid. R.C.P. Edin., 1885.

MR. MELHUISH, Chemist, of 134 William-street, Sydney, has just received a full supply of the new B.P. lamels (discs) for ophthalmic purposes, such as Cocaine, Physostigmine, and Atropine.

MR. BRUCK, of 35 Castlereagh-street, Sydney, will receive a very large shipment of *New and Standard Medical Works* on or about May 20.

REVIEW.

SELECT EXTRA-TROPICAL PLANTS.

BY BARON SIR FERD. VON MUELLER, K.C.M.G., F.R.S., M.D., &c., GOVT. BOTANIST FOR VICTORIA. New Victorian Edition, revised and enlarged. Melbourne: John Ferris.

THIS is a work of great practical interest, and the fact of its having arrived at a new edition sufficiently indicates that it is so adapted as to supply a real demand for information regarding the utilitarian resources of the vegetable kingdom on the part of colonists and others. The colonial agricultural interest is not infrequently charged with a lack of originality in attempts to extract from mother earth the greatest possible amount of her native wealth. There is probably some truth in this imputation of slavish adherence to the customs of the mother countries in regard to agricultural produce. Baron Von Müller has rendered it impossible to plead lack of knowledge as an excuse for the absence of enterprise in this all-important department, and he certainly deserves the thanks of all interested for thus placing the more practical aspects of his botanical erudition at the command of every energetic cultivator of the soil. The book is doubtless familiar to many of those for whom it is specially written. For the information of others of the same class it may be noted that the book consists of a series of notes on several thousands of plants (including trees and shrubs) which are of practical utilitarian importance. The notes embrace information as to the habitat, characters, uses, modes of cultivation and preparation of the different species, with hints upon the climatic and other conditions of their culture. The plants are arranged alphabetically, but there are appendices in which the plants are grouped both in geographical and scientific series, and an index to the common names of many of them. The alphabetical arrangement, according to the scientific names, is ill-adapted to the requirements of those to whom the book is otherwise most useful. It would probably have been a more suitable arrangement to make the geographical distribution the basis for the descriptive treatment, while indications might have been given otherwise of similarities in climate and conditions which might render naturalisation elsewhere desirable. The reprint and translation of the book in other countries are evidence of its unique and valuable practical character, and the name of Baron Von Müller is a sufficient guarantee for its scientific accuracy. The typography and *tout ensemble* of the book leave little to be desired, and reflect grate credit on the publisher.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number. All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, MAY 15, 1887.

EDITORIALS.

PROPRIETARY MEDICINES.

THE unsatisfactory state of the laws in the Australasian colonies with regard to the sale of proprietary medicines was shown very obviously by the evidence given at an inquest held in Macdonaldtown, a suburb of Sydney, on the body of a child, three and a half years of age, named Catherine Mabel Jones. The mother had given it a "Stedman's Soothing Powder," an apparent imitation of "Steedman's Soothing Powder." The child was found to be dead a few hours after the administration of the powder. A *post-mortem* examination and analysis of the viscera was made, the result being that the analyst reported he had found about a grain of morphia in the parts submitted to him. He also examined six other powders similar to the one given to the child, and found them to consist of morphia and magnesia, there being from a quarter of a grain to a grain of the former in each. With powders containing such a dose of this narcotic it was no wonder the child died, and as such powders are generally made up in hundreds at a time, we have not the slightest doubt that the deaths of other children have occurred from the same cause, and would earnestly warn chemists against their sale. We are of opinion that a law compelling the registration of the formula from which every proprietary medicine is prepared is urgently required, how much so will, perhaps, hardly be known until searching enquiry is made into the subject. As soon as the committee lately appointed by the Legislative Council of N.S.W., on the motion of the Editor of this Journal, to examine into the state and operation of the laws relating to the practice of medicine and surgery in that colony, has concluded its labours, it is his intention to ask for the appointment of another committee to enquire into the subject of the sale of proprietary medicines, and to suggest regulations for the protection of the public in this matter.

THE CULTIVATION OF VACCINE LYMPH IN AUSTRALIA.

THE chairman of the Central Board of Health of Victoria (who is a layman), either from ignorance of the real state of the case, or with that assumption of omniscience in medical matters which is so common amongst outsiders, said in a recent report, when speaking of the supply of calf and humanised vaccine lymph—"that as the other colonies are apparently unable to cultivate lymph, the Governments of New South Wales, South Australia and Queensland, should be asked to contribute towards the maintenance of a lymph farm in Victoria." The health authorities in the three colonies mentioned are certainly as competent to carry on such an establishment as those of Victoria, so that the insinuation that they are "unable" to do so is a gratuitous impertinence, but we freely admit that the respective Governments of these colonies have shown culpable negligence in the matter. We think, however, that one cultivation station for the whole of Australasia is quite sufficient, and willingly endorse the suggestion that it should be maintained by the joint contributions of all the colonies. As there is one already in existence in Victoria, we think this should be the one to be carried on, the right of entry and inspection being of course granted to the health authorities of the contributing colonies, who should have the right of ceasing to contribute if the conduct of the lymph station was found to become careless or unsatisfactory.

CREMATION IN NEW SOUTH WALES.

THE Cremation Bill introduced by the Hon. J. M. Creed in the Legislative Council, has for the second time passed that Chamber, and on May 5th, was read the first time in the Legislative Assembly, on the motion of Mr. Trickett, who has charge of it in the Lower House.

The bill is the same as that of 1886, except in some verbal alterations, and by the omission of what was clause 8 in the old bill. The omission of this clause weakens the measure in its sanitary aspect, and its omission is therefore to be regretted. By it, provision was made that, in the event of a serious epidemic occurring, the Governor, with the advice of the Executive Council, might suspend the operation of clause 5 (which requires certain certificates to be handed to the Registrar, prior to a cremation permit being issued), for such time and in such places as he may think right.

Should a serious outbreak of cholera or yellow

fever occur, in which the deaths from these diseases might amount to hundreds a week, the fatal cases would be so rapid in their course that, in the majority of cases, no medical practitioner would have been in attendance on the deceased for seventy-two hours prior to the death, and all professional men would be so fully employed in their attendance on the living, that the alternative of a *post-mortem* examination would be impracticable.

When we are subject to an outbreak of these diseases, which must occur sooner or later, it would be a great sanitary gain to cremate all the bodies of those who fall victims to these fell maladies, and thus insure the destruction of the germs by which they are propagated, instead of burying them in the earth to be brought into activity at a future time when the graves are disturbed, or water draining from them is used for domestic purposes.

CASE OF CONSPIRACY AGAINST A MEDICAL MAN IN SYDNEY.

DR. H. G. A. WRIGHT, a much respected medical man, who has practised in Sydney for many years, appeared at the Water Police Court on April 22nd in answer to a charge made against him by Amy Smith, that he had committed a criminal assault upon her. The result being the prompt dismissal of the case by the sitting magistrate, and the immediate arrest of the woman, her reputed husband, John Smith, and an accomplice, Richard Sydney Marjoram, on a charge of conspiring to extort money from Dr. Wright. The three prisoners were committed for trial. It appears that the woman is not the wife of the prisoner Smith, but, by her evidence, is the wife of a Wesleyan Minister named Thomas, whom she had left.

The sympathy, not only of the profession, but of the public generally, is with Dr. Wright, suffering under the mental distress consequent on a charge so infamously made.

As the prisoners are yet untried we refrain from further comment until the termination of the trial, when we will go more fully into the subject, one of such vital importance to every medical man.

In the October number of the *A.M.G.*, we warned our readers relative to the "Australian Mutual Prudential and Medical Assurance Society," at that time just established in Sydney. That our warning was fully justified has been forcibly shown by the sudden collapse of the Association, and by the abject apology of Sir Henry Parkes in the Legislative Assembly of New South Wales, for his folly in allowing his name to be placed on the list of directors.

THE LONDON UNIVERSITY COLLEGE HOSPITAL.

At the request of Mr. Berkeley Hill, F.R.C.S., Senior Surgeon to University College Hospital, we call the attention of our readers who were educated at University College, London, to an appeal which appears in our advertising columns for funds to rebuild the Hospital. Those who recollect the old building will have no difficulty in understanding that it must be rebuilt to enable it to provide for the increasing demands of the Medical School. The Council of University College are resolved to build a hospital on an enlarged site, which shall be an exemplar, in construction and arrangement, for the treatment of the sick and the study of disease. It is in contemplation to dedicate a ward in the new building to former students of U.C. who are settled in the colonies, and to inscribe their names in a long list, it is hoped, in their memory. The number of patients treated has been, and is still increasing rapidly. The number of in-patients in the last fifteen years has advanced from 1,600 to 3,000 annually, the out-patients from 8,900 to 12,700, and the casualties from 7,000 to 20,000 in the like period. We trust that old University College men will assist in the education of their successors by liberally responding to the appeal of the Council.

We also call the attention of our readers to the announcement of the *New York Post-Graduate School and Hospital*, which appears in our advertising columns. This institution is a school of clinical medicine and surgery to which only qualified practitioners are admitted. The teachers are members of the medical profession of New York, who, in their personal connections with the city hospitals and asylums, control a vast clinical material, which is submitted to the members of the class for examination and study under the supervision and with the assistance of the teachers in the various departments. The members will be brought into intimate personal contact with the patients, where the clinical features of each case may be minutely and leisurely studied and thoroughly understood. The President of this institution is Dr. Roosa, one of the most eminent aural surgeons of the day, and amongst its teachers we notice such well-known names as Emmet, Hammond, Lee, Fox, Dana, Roberts, Ranney, and others. During every session several hundred practitioners are in attendance upon its numerous clinics, and we do not hesitate to recommend any colonial practitioners, visiting the United States, to avail themselves of the facilities for clinical study offered by this institution.

LETTER TO THE EDITOR.

MEDICAL ETIQUETTE.

(To the Editor *Australasian Medical Gazette*.)

SIR.—You would oblige by your opinion on the following:—A, a patient's relative, calls on B, a medical man, and asks him to go and see a case of ununited fracture of nine weeks' standing, which has been attended by C. B explains to A that he cannot see the case unless in consultation with C, and advises A to get C to visit the patient again, and that if a consultation is requisite he will be very happy to meet C.

B hears no more of the case for five weeks, when A again calls on B and tells him the fracture is still ununited, and that when he proposed to C to call in B, C pressed him to have either of two other medical men practising in the same town, and that when A said he preferred B, C said that B was *too expensive* to call in. However A insisted that B should be called in, and B met C on the case in a friendly manner, and said nothing of the previous circumstances now described.

Still more recently D sent for B to call at her house. When B arrived D said she wished him to see her child, who was suffering from scarlet fever, as her throat had got much worse, and she was alarmed about it. B said he could not see the child except in consultation with C, who was attending the child. B also said that it was usual for the throat to be bad in scarlet fever, and that perhaps it would be better to leave the case a little longer under C's treatment, and it might be found that no consultation would be necessary. D said she would have a consultation at once, as she was too anxious about her child to wait any longer. She also said she would send B (who lived close by) word when C arrived. Soon after, B received a message from D to say that she would not require him to call that evening.

The following is the version of what occurred as told by D to B:—When C arrived she told him that she wished to call in Dr. B to see the child. O at once suggested Dr. E. D said she preferred Dr. B. Dr. C still pressed her to call in Dr. E. D then said "Have you any objection to Dr. B?" C answered evasively "Oh! we all know Dr. E for years and would rather have him, of course if you insist on calling in Dr. B, the laws of society compel me to meet him." It ended in Dr. E being called in.

Now, sir, as C has shown such a determination to injure the practice of B (who is a new arrival), as proved by these two cases that have actually come under B's notice, what should B do the next time he is asked to see one of C's patients? Is B bound to act with the professional etiquette he has hitherto observed towards C, and thereby lose the consultations, or will he be justified, in self-defence, in taking the case out of C's hands at once, if so requested, as he was in the two cases mentioned, by the parties themselves.

Your opinion in next issue would greatly oblige,
Yours, &c., M. D.

[If the account given by our correspondent is strictly accurate, we think that C did not behave in the first instance with that fairness and courtesy which is due to a professional brother; in the second he was even more to blame in the course which he pursued. We, however, cannot endorse any suggestion that would result in the taking over of a case by a second practitioner whilst it still remained in the hands of the first attendant, but under the circumstances related as to C's conduct, we think that B would be justified in taking up a case, after C, by the patient's friends' request, had quite ceased attendance on it.—ED. A.M.G.]

THE MONTH.

NEW SOUTH WALES.

THE Colonial Secretary of Fiji, the Hon. J. B. Thurston, has expressed to the Government of New South Wales his high appreciation of their action in reference to the outbreak of smallpox on board the steamer "Preussen." Mr. Thurston in his letter states that he fears that the establishment of the German line of steamers to Tonga and Samoa will expose the inhabitants of these islands to a new and grave danger.

DR. ASHBURTON THOMPSON, the Chief Medical Inspector of the N. S. W. Board of Health, visited Prospect Camp on April 30, to hold an inquiry on behalf of the Government into the sanitary condition of the camp. After taking evidence, he minutely inspected the locality and its surroundings, and the result of his investigations and observations will probably form the subject of a report. It is understood that, in view of the prevalence of typhoid fever at the camp, the authorities will be advised to close the Public School there for a time.

A RAILWAY ambulance class was opened on May 4, at Albury, by Dr. Cleaver Woods, and the introductory lecture was delivered by that gentleman in one of the station waiting-rooms; about 40 railway men attended. These lectures, with practical workings, will be delivered fortnightly, over a term of three months.

AT the monthly meeting of the Linnean Society of New South Wales, held in the Linnean Hall, Elizabeth at Little Bay Hospital, and pointed out that the microbe Bay, Sydney, on April 27, Dr. Katz exhibited preparations of the bacillus of typhoid fever obtained before them was the cause of typhoid fever, as constantly present in that disease and never found in others. According to quite recent investigations with regard to the transmissibility of the bacillus of typhoid fever to animals—mice, rabbits, guinea-pigs, and dogs—there could be no doubt that this micro-organism was able to make the animals sick, and to kill them under certain circumstances. With relation to the biology of the bacillus, a good deal of work remained to be done, and a radical cure of the disease, or a possible protective inoculation being still a desideratum, special attention should be paid to the more practical part of the life history of the fungus, especially to its behaviour in the dejections from typhoid fever patients. Dr. Katz likewise exhibited the bacillus of leprosy under the microscope.

THE newly elected committee of the Medical Section of the Royal Society of N.S.W. for the forthcoming session consists of the following gentlemen:—Chairman, Dr. P. Sydney Jones; Secretaries, Dr. M'Cormick and Dr. Jenkins; Members of Committee, Professor Dr. A. Stuart, Dr. Knaggs, Dr. Chambers, Dr. Crago.

A MEETING of the Sanitary Section of the Royal Society of New South Wales was held in the Society's rooms, Elizabeth-street North, on April 19, when the following gentlemen were appointed office-bearers for the forthcoming session:—Chairman, Dr. H. N. MacLaurin; secretary, Dr. Reuter E. Roth; committee—Drs. W. H. Goode, F. H. Quaife, H. F. Ross, and Messrs. E. Sager, J. B. Henson, and F. B. Kyngdon. Some routine business was transacted, and the meeting terminated.

AT a meeting of the Microscopical Section of the Royal Society of New South Wales, held on April 18, the following gentlemen were elected as office-bearers

for the ensuing session :—Chairman, Mr. F. B. Kyngdon; secretary, Mr. P. J. Edmunds; committee, Drs. H. G. A. Wright and Eric Sinclair, and Messrs. G. D. Hirst and S. MacDonnell.

THE foundation stone of a fever hospital at Temora was laid on April 26.

DR. F. P. BARTLETT, of Cowra, has gone to England for twelve months; during his absence, Dr. Thos. Geraty will carry on his practice.

DR. T. B. BELGRAVE, of 127 Phillip-street, Sydney, has removed to "Haslemere," George-street, Burwood.

DR. C. D. CLARK, of North Shore (Sydney), has removed from Mount-street to "Walworth," corner of Berry and Walker streets.

DR. H. L. HARRIS has been appointed Coroner for the district of Raymond Terrace.

DR. G. C. JACKSON, of Katoomba, who occupies a large house, centrally situated, with extensive grounds, and commanding a magnificent view of the surrounding beautiful scenery, would be glad to receive two or three invalids who may require medical supervision.

DR. C. W. MORGAN, of Newcastle, has been appointed Deputy Licensing Magistrate at Newcastle, and Dr. G. Duncan, of Emu Plains, a member of the Licensing Court at Penrith.

DR. A. S. OGG, formerly of Gundagai, has settled at Milton, the centre of a dairy-farming and agricultural district, 155 miles S. of Sydney.

DR. A. RENWICK has been appointed President of the N. S. Wales Commission for the Adelaide Jubilee International Exhibition.

DR. C. A. E. Sheaf, late of Toowoomba (Qu.), has commenced practice at Emmaville, the centre of a rich tin-mining district, 447 miles N. of Sydney.

DR. G. E. TWYNAM, of Macquarie-street, Sydney, has returned to the colony from his trip to England.

MRS. J. MACKAY, favourably known to a number of medical men in Sydney, has opened an "Invalid's Home," for the reception of medical and surgical non-infectious cases, at No. 8 Darlinghurst Road.

NEW ZEALAND.

THE Government have proclaimed a new lunatic asylum at Wellington, to be known as the "Porirua Lunatic Asylum."

THE HON. DR. M. S. GRACE, of Wellington, has been appointed Surgeon-General of the N.Z. Volunteer Forces.

DR. C. J. RUSSELL, of Christchurch, who, on January 15, was committed for trial on two charges of procuring abortion, has been found guilty; he has been sentenced to seven years penal servitude.

DR. T. BENNETT, of Johnsonville, has removed to Bull's (Rangitikei), in a pastoral and agricultural district, 120 miles N.E. of Wellington.

DR. I. W. DALZELL, late of Lawrence, and formerly of Opotiki, has commenced practice at Winton, in a saw-milling district, 19 miles N.W. of Invercargill.

DR. E. G. L. ERSON, of Otahuhu, has resigned his commission of Honorary Surgeon of the Auckland Royal Dragoon Volunteers.

DR. P. J. O'N. O'CARROLL, of New Plymouth, has resigned his position of Honorary Surgeon to the Inglewood Rifle Volunteers, N.Z.

QUEENSLAND.

DR. H. W. BROWNRIGG, late Surgeon of the Palmer River District Hospital at Maytown, has succeeded to the practice of Dr. A. R. Broom, at Goondiwindi, a pastoral township close to the N.S. Wales border, 208 miles S.W. of Brisbane.

DR. W. M. FISHER, of Townsville, has removed to Cloncurry, in a pastoral and copper-mining district, 1,500 miles N.W. of Brisbane.

DR. ALEXANDER MACKINTOSH, late of Sunny Corner (N.S.W.), and formerly Resident Medical Officer at the Ipswich Hospital, has commenced practice at Croydon, a gold-fields town in Northern Queensland.

THOMAS ROSS, L.R.C.P. & R.C.S. Edin., 1881, of Townsville, is dead; the deceased gentleman was formerly Assistant Physician at the Sick Children's Hospital, Edinburgh.

VICTORIA.

AT a meeting of the Council of the University of Melbourne, held on April 18, the following motion was agreed to :—"That two of the physicians attending the in-patients of the Melbourne Hospital be appointed clinical lecturers on medicine, and that two of the surgeons attending the in-patients at the Melbourne Hospital be appointed clinical lecturers on surgery, until the end of the July term, at a salary at the rate per annum of £125, together with one-fourth of the fees paid to the University for clinical lectures in medicine and surgery, provided that these two sums do not together amount to more than £250. The Council will require that a regular lecture roll of the attendance at these lectures be kept." It was also decided to ask the medical faculty to nominate four of the medical officers of the hospital as clinical lecturers.

THE Senate of the Melbourne University have offered positions of lecturers in clinical medicine to Drs. J. Williams and P. Moloney, and in clinical surgery to Messrs. T. N. Fitzgerald and T. M. Girdlestone, till the end of the July term, the total remuneration to be at the rate of £500 a year, together with the fees for clinical instruction collected by the University.

DR. SHIELDS, the Government Medical Officer, and the Officers of the Central Board of Health, are making careful inquiries as to the predisposing causes of typhoid fever in certain districts where the disease has been exceptionally prevalent.

THE Officers of the staff of the Melbourne University have presented Dr. Brownless with an illuminated address, congratulating him on his recent election to the Chancellorship.

THE President of the Victorian Board of Health recommends the establishment of a lymph farm, and that the other colonies subscribe towards its maintenance. He also suggests that a good supply of lymph should be kept at the first ports of call.

NOTWITHSTANDING the adverse opinion expressed by the Medical Society of Victoria with reference to the proposed Hospital for Consumptives, the committee appointed to arrange for the establishment of the institution, influenced principally by an article that appeared in last issue of the *A. M. Gazette*, have decided to erect a building at Sorrento designed upon the cottage system of hospital. It is to be named the Sanatorium for Consumptives.

NEARLY 30 cases of measles have lately occurred at Romsey and neighbourhood; the local school has been

closed to prevent the spread of the disease as far as possible.

THE class of railway employés established at Spencer-street Railway Station, Melbourne, to receive instruction from the series of lectures delivered by Dr. R. Robertson, in connection with the St. John Ambulance Association, has been examined by Dr. A. Honnan, with the result that 16 students passed out of a total of 32 examined.

DRS. A. V. M. ANDERSON, W. R. BOYD, G. J. A. B. HALFORD, G. C. RENNIE, and J. S. THOMSON have been appointed Resident Medical Officers at the Melbourne Hospital for the ensuing 12 months.

SURGEON-MAJOR CHARLES S. RYAN has been appointed to be Acting Medical Officer to the Head Quarters Staff and the Victorian Artillery, during the absence of Brigade-Surgeon Fulton on leave.

MR. C. R. BLACKETT has been appointed Victorian Government Analyst, vice Mr. William Johnson, deceased.

DR. J. W. D. HOOPER, for two years Resident Medical Officer at the Women's Hospital, Melbourne, has commenced practice at 101 Collins-street East, the residence of the late Dr. J. Blair.

DR. A. J. W. KEENAN, for the last twelve months Resident Surgeon at St. Vincent's Hospital, Sydney, has returned to Victoria and resumed practice at "Delville," Fitzroy-street, St. Kilda, a fashionable suburb of Melbourne.

DR. JOHN REID, of Melbourne, has removed from 11 Spring-street to 143 Collins-street East.

DR. G. J. SCANTLEBURY has commenced practice at Ballarat, Dr. J. B. Walter at Avoca, Dr. J. Macnaught at Winchelsea, and Dr. A. H. Gordon at Cheltenham.

WESTERN AUSTRALIA.

DR. J. T. LAFFAN, J.P., Resident Government Medical Officer at Wyndham (Cambridge Gulf), has been appointed to act temporarily as Government Resident, the Magistrate of the Local Court, Chairman of the Court of General Sessions, and Sub-Collector of Customs and Internal Revenue of the East Kimberley District.

MEDICAL APPOINTMENTS.

Anderson, Eugene Wilton, M.B. & Ch.B. Melb.; L.R.C.P. & R.C.S. Edin., appointed Resident Medical Officer at the Women's Hospital, Melbourne, vice Dr. Hooper, resigned.
 Atkins, Thomas Deatly, M.R.C.S. Eng. & L.R.C.P. Edin., to be a Public Vaccinator for South Australia.
 Beckett, Thomas George, L.R.C.P. & R.C.S. Edin., to be Public Vaccinator for Charlton, Vic., vice Dr. Jas. Smeal, resigned.
 Bennett, Thomas, L.R.C.S. Irel., to be Public Vaccinator for the districts of Bull's and Sanson, N.Z.
 Bird, Edwin Jeffrey, M.B. Melb., to be Health Officer for Shire of Whittlesea, Vic.
 Brownrigg, Herbert Watson, L.K.Q.C.P. Irel., L.R.C.S. Irel., to be Government Medical Officer at Goondiwindi, Qu.
 Carney, John Henry, M.B. Melb., to be Public Vaccinator at Kyabram, Vic., vice Dr. W. G. McLenan, resigned.
 Dalsell, Isaac William, L.R.C.S. & R.C.P. Edin., to be Public Vaccinator for the district of Winton, N.Z.
 Deck, Henry O'Brien, M.B. Melb., appointed Resident Medical Officer at the Melbourne Hospital.
 Dickinson, William Miller, M.B., L.R.C.S. Irel., to be Health Officer, shire of Nunawading, Vic.
 Dunlop, William, M.B. & Ch.M. Glas.; L.F.P.S. Glas., elected Resident Surgeon of Gymph Hospital, Qu.
 Ewart, John, M.D. & Ch.M. Edin., appointed Resident Surgeon of the Timaru Hospital, N.Z., vice Dr. H. V. Drew, resigned.
 Fetherston, Richard Herbert Joseph, M.B. & Ch.M. Edin., L.R.C.S. Irel., L.K.Q.C.P. Irel., appointed Assistant Resident Medical Officer at the Women's Hospital, Carlton, Melbourne, vice Dr. W. N. Nevill, resigned.

Fisher, Walter Mulrea, L.S.A., Lond., to be Government Medical Officer at Cloncurry, Qu.
 Fox, Henry Tregellis, M.B.C.S.E., to be Public Vaccinator at Beechworth, Vic., vice Dr. M. F. Cleary, resigned.
 Hood, James Crockett, M.D. & Ch.M. Roy. Univ. Irel., to be Public Vaccinator at Rupanyup, also Health Officer for Dunmunkle shire, E.R., Vic.
 Horne, George, M.B. & Ch.B. Melb., to be Public Vaccinator at North Fitzroy, Vic., vice Dr. F. Daniel, resigned.
 Kiernander, Herbert Byrne, L.R.C.P. & R.C.S. Edin., to be Government Medical Officer and Vaccinator for the district of Murrumburrah, N.S.W.
 Lawson, George Langrigg Leathes, L.R.C.P. Edin., M.R.C.S. Eng., to be Government Medical Officer and Vaccinator for the District of Balranald, N.S.W.
 Losberg, W. Henry von, M.D., to be Government Medical Officer at Ipswich, Qu.
 Mackintosh, Alexander, M.B. & Ch.M. Glas., to be Government Medical Officer at Croydon, Qu.
 MacLean, Hector Rath, M.B. & Ch.M. Edin., to be Health Officer for shire of Wyndham, Vic., vice Dr. D. P. MacLean, resigned.
 McMurray, Wahab, M.D. & Ch.M. Roy. Univ. Irel., to be Government Medical Officer and Vaccinator for the district of Wallangatta, N.S.W.
 Montgomery, John Park, M.B. & Ch.B. Melb., to be a Surgeon to the Victorian Mounted Rifles.
 Nolan, Lester Andrew, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Surgeon to the Victorian Mounted Rifles.
 Ogg, Alexander Stark, M.D., M.R.C.P.S. Ont., L.R.C.P. Edin., to be Government Medical Officer and Vaccinator for the District of Dowling, N.S.W.
 O'Flannagan, Andrew Joseph, L.R.C.S. Irel.; L.K.Q.C.P. Irel., appointed Resident Surgeon at St. Vincent's Hospital, Sydney, vice Dr. A. J. W. Keenan, resigned.
 Pardey, Charles William, M.B. & Ch.B. Melb., to be Public Vaccinator at Swan Hill, Vic.
 Reid, George Marr, M.B. & Ch.M. Aberd., to be Public Vaccinator for Dean's Marsh and Lorne, Vic., vice Dr. W. B. Wilkie, M.B., resigned.
 Rudall, James Thomas, F.R.C.S. Eng., appointed Surgeon to Alfred Hospital, Melbourne, vice Dr. J. Blair, deceased.
 Simpson, Donald, M.B. & Ch.M. Glas., to be Public Vaccinator at Oakleigh, Vic., vice Dr. W. E. Stock, resigned.
 Tomline, William Henry, M.R.C.S. Eng., to be Government Medical Officer and Vaccinator for the district of Lower Richmond River, N.S.W.

INTERCOLONIAL MEDICAL CONGRESS,

Adelaide, Aug.-Sept., 1887.

THE following is a list of Papers promised up to May 9 (the final date for notice being June 30):—

On Hip Joint Disease; on Post-nasal Vegetations; on the Surgery of certain Diseases of the Nose; on Myositis Ossificans; on Bigelow's Operation; on the Surgery of the Kidneys; on the Excision of the Larynx; on the History of Ovariectomy in Australia; on the Alexander-Adams Operation for shortening the round ligaments; on 20 cases of Iaparotomy for various affections, including Extra-uterine Pregnancy; on an Operation for shortening the round ligaments; on the after treatment of Puerperal Women, with especial reference to the use or abuse of the uterine douche; on the Treatment of Pulmonary Hydatid; on Tuberculosis; on Fear as a factor in producing many of "the Symptoms following Snake-bite"; on Dilatation of the Stomach; a Demonstration of Bacilli; on the Influence of the Australian Climate in Phthisis; on Filariæ Disease; on Animal Vaccination; on Typhoid Fever; on some Diseases peculiar to Fiji; on Typhoid Fever at Teetulpa; on some forms of Dropsy and other Diseases in Central Australia; on Cremation; on the Relation of the Practitioner to the State; on the Relation of the Practitioner to the Public (not definitely promised); on the Hospital Systems of the Australian Colonies; on the Sewage Farm; on Sight and Colour Perception in non-Caucasian Races, with special regard to the Aborigines of Australia, New Zealand, and Fiji; on Cataract Operations; Notes on Kye Cases in Adelaide; on some Questions in Ophthalmology; on some Native Queensland Drugs; 14 other Papers promised, but not yet named.

REPORTED MORTALITY FOR THE MONTH OF MARCH, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	834	210	103	..	..	3	4	11	13	18	11	9	6
Suburbs	200,000	804	386	168	..	3	3	3	28	24	28	18	10	6
NEW ZEALAND.														
Auckland	36,553	116	55	40	..	1	..	5	..	24	3	..	..	..
Christchurch	15,684	38	23	15	..	..	..	1	1	8	1	..	..	..
Dunedin	24,233	64	44	20	..	..	1	..	2	13	5	1	1	1
Wellington	25,945	94	68	44	..	..	..	..	6	11	6	2	2	1
QUEENSLAND.														
Brisbane	92,571	109	45	25	{	..	6	1	7	13	11	1	3	4
Suburbs	41,082	182	75	44	{	..	..	..	..	..	..	..	..	..
SOUTH AUSTRALIA.														
SOUTH AUSTRALIA.....	307,216	991	386	160	..	..	3	2	19	52	39	22	4	13
Adelaide	42,904	115	81	26	..	..	1	..	3	8	15	7	..	..
TASMANIA.														
Hobart	29,854	83	64	36	..	..	3	..	10	9	3	4	2	1
Launceston	18,922	56	29	13	..	..	..	..	3	3	2	1	1	1
Hospitals, Asylums, Gaols, &c. .	1,370	...	35	..	..	..	..	..	..	..	..	..	..	..
Country Districts.....	87,658	248	76	..	..	..	1	3	..	14	..	..	..	..
VICTORIA.														
Melbourne	69,774	194	126	..	868	1	..	8	4	59	78	88	40	20
Suburbs	275,606	1,131	703	..	..	..	..	..	..	..	..	..	..	27

METEOROLOGICAL OBSERVATIONS FOR MARCH, 1887.

STATION.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.
	Maximum Sun.	Maximum Shade.	Mean Sun.	Mean Shade.		Inches	Depth.	
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	..	99.8	69.	48.4	29.905	..	..	..
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	143	78.5	67.2	50.	..	8.00	7	89
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	106.7	88.4	74.3	63.5	30.000	12.088	30	81
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	147	85.6	61.7	35.8	..	1.021	6	62
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E. ....	..	..	..	..	..	..	..	..
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	..	84.5	61.	39.8	29.850	2.57	15	73
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	..	87.	62.2	32.	29.938	2.49	10	68
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	..	93.	65.	42.	29.926	.785	7	..
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	..	84.9	71.2	58.7	30.046	2.87	17	75
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	140	75.	61.9	45.	..	1.902	14	79

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

ON DIGESTIVE FERMENTS.

READ BEFORE OTAGO BRANCH OF NEW ZEALAND
MEDICAL ASSOCIATION.

BY D. COLQUHOUN, M.D. LOND., M.R.C.P.
LOND., LECTURER ON THE PRACTICE OF
MEDICINE, UNIVERSITY OF OTAGO, N.Z.,
AND PHYSICIAN TO THE DUNEDIN HOSPITAL.

IN 1880, Dr. Roberts, of Manchester, gave the Lumleian Lectures at the Royal College of Physicians in London, on the "Digestive Ferments, and the Preparation and Use of Artificially Digested Food." These lectures, which I had the privilege and pleasure of listening to, mark, I believe, a distinct era in the treatment of diseases in which malassimilation of food plays a part. It was not that Dr. Roberts made, or claimed to make, any new discoveries in the physiology of digestion, or that he was the first physician to teach the use of partly digested food. Like all other scientific workers, he was indebted to his contemporaries and to those who had worked before him in the same field, and especially to the scientific chemists who had been able to supply him with the necessary material to work with. He was able, in a peculiarly happy manner, to unite the work of the chemist, physiologist and physician. Most of us are familiar with the old controversy that raged between the chemist and physician. Troussseau admitted "the desirability of the physician having a very extensive knowledge of chemistry, for the purpose of convincing him of the vanity of the pretensions of chemists." If the chemist looked upon the human body too much in the light of a test tube or a retort, the physician went a little too much the other way. Too much was expected, and, perhaps, too much was claimed by the exponents

of animal chemistry in its early days. The results of the laboratory were not attained in practice. The market has been flooded, from time to time, with all kinds of foods, chemically unimpeachable, but, too often, practically useless or disappointing. To Dr. Roberts, however, is due the credit of having introduced to the medical profession certain modes of preparing food, which have proved of great service already and promise to be still more useful, and which have the merit of being easy of application. To-night we have the opportunity of seeing some of the processes whereby various foods can be partly digested by the use of certain animal ferments. We have heard a good deal lately of the superior enterprise of German and other foreign traders in the markets of the world, over English houses, and I think our profession may justly congratulate Messrs. Burroughs, Wellcome & Co., on the fact that in their department of business an English firm has proved itself free from such reproach.

In introducing a discussion on the use of digestive ferments I think the questions we may try to decide are:—

1. To what extent can foods be prepared for digestion? and
2. In what condition and to what extent are such prepared foods useful?

It may conduce to clearness if we begin by a brief resumé of the nature of foods in general use and of the chemistry of ordinary digestion.

All foods can be classed under two heads—the inorganic and organic.

The inorganic foods—water and salts—are simply absorbed in the stomach and intestines, and serve for the solution and help the absorption of other foods. They have only to be taken in such quantities as the organism demands, and bear no special proportion.

The organic foods consist of those containing nitrogen and of the non-nitrogenous. The latter consist of amyloids in which the oxygen and hydrogen are in the proportion necessary to form water, as $C_6 H_{10} O_5$ in starch, and of fats which contain little oxygen.

All the organic foods throw more or less work on the digestive system before they can be assimilated. They are taken into the stomach as a rule in an insoluble form, and have first to be rendered soluble and diffusible. This is the first process of digestion. They have then to be absorbed by the blood-vessels and lacteals, and are by means of the blood-vessels conveyed to the tissues. In the tissues the ultimate digestion of food takes place, each tissue selecting from the blood the material it wants for its own purposes,

and elaborating it, and converting it into living organic matter.

We have physiologically and practically two stages at least in normal digestion, and we may and actually have constantly two forms of indigestion or malassimilation to consider in disease, often so intermixed, however, that it is difficult or impossible to say exactly which stage of the digestive process is primarily at fault. Of the processes of the first stage of digestion, viz., that which goes on in the alimentary canal, we know something; of the processes of ultimate digestion we know very little, and can only judge by results.

Leaving out of consideration the mechanical aids to digestion, the mastication by the teeth, the churning action of the stomach and the peristaltic action of the intestines, we know that all foods are acted on by the following juices:—

1. *Salivas*.—An alkaline fluid which converts starch into sugar.

2. *Gastric Juice*.—An acid fluid whose chief function is to make insoluble albumens into a soluble and exceedingly diffusible form of albumen.

3. *Pancreatic Juice*.—An alkaline fluid which meets the food as it leaves the stomach and converts starch into sugar, insoluble albumen into soluble peptones, and emulsifies and splits up fats.

4. *Bile*.—An alkaline fluid, the action of which is still, I believe, doubtful, but which is generally looked upon as being antiseptic, stimulating peristalsis, favouring the absorption of fat by the lacteals; and partly an emulcent of fats.

5. *Enteric Juice*.—Alkaline, probably acts on sugar and milk.

Besides these activities it is worth noting that both the stomach and pancreas, and probably the intestines, secrete special milk-digesting ferments which are peculiarly active in children, and are probably in the first few months of life the only digestive ferments which are fully developed.

While the digestive powers of man have a wider range than those of most animals, they are weaker in detail. The same ingenuity which has invented thousands of labour-saving machines has found out numerous ways of supporting life and of saving the digestive juices unnecessary labour.

There is hardly a savage race so low as not to practise some means of predigesting food; and as for civilised races we can say literally with Owen Meredith—

"We can live without art, or music, or books;
But civilised man cannot live without cooks."

We must cook our food, in other words prepare it for the digestive juices, or die. We have to pay for our ingenuity in weakened digestive powers.

Besides the cooking of food there are numerous other methods, based upon experience, of rendering it less burdensome to the stomach and intestines. The rennet, or extract of calves' stomachs, has long been in use to partly predigest milk. The sweetbread or pancreas is a favourite popular dish for invalids and old people. The oyster is as popular, because, when raw, it carries its own digestive ferment with it. Ox-gall is an old remedy in jaundice.

The gizzard of fowls and the stomach of the ostrich have been used for indigestion. The Maoris, I believe, were in the habit of burying fish until its fibres have been dianoxiated by putrefaction, and then using it as food. English cooks attain the same end by hanging up game. Norman peasants allow milk to become sour and use it as food for invalids. It would be easy to multiply such examples. Of late years, as we have seen, more scientific attempts have been made to predigest food. Pepsin from the pig's stomach, with hydrochloric acid, and hydrochloric acid alone, have been largely used as helps to digestion. But, as might have been expected from its properties, Pancreatic Extract has proved a far more valuable agent in preparing foods.

The special form of Pancreatic Extract which is used in to-night's experiments, is that of Fairchild's. It is here shown in the form of a powder, united with a suitable quantity of bicarbonate of soda. In addition to various foods acted on by Fairchild's Zymine, there is also a specimen showing the action of pepsin and hydrochloric acid on meat, and there are also various specimens of the same foods, without the addition of ferments, for comparison.

I have also to call your attention to the specimen of Cod Liver Oil and Malt exhibited. Malt is an amyloid, half-way between the insoluble starch and soluble sugar. It also contains a ferment capable of converting starch into sugar, and some albumenoid matter, and has been largely used of late years as a food, and as a helper to the digestion of other foods.

I have now tried to answer the first question, viz.:—To what extent can foods be prepared for digestion? And we have seen that most of the chief actions of the digestive juices can be effected on food before it is taken into the stomach.

The second question proposed: In what conditions and to what extent are such prepared foods useful? is one which is more difficult to answer.

At the very outset, we meet with the difficulty that the pancreatised food has first to pass into the stomach, where it meets with an acid secretion, and where it is exposed to a surface which is

accustomed only to absorb acids, peptones, water and salts.

I have taken some fully pancreatised beef-tea and some fully pancreatised milk, and to each have added Fairchild's scale pepsin and dilute hydrochloric acid. Both specimens of food have been kept for an hour at a temperature of 100° F. This is as near as we can get to what actually happens when pancreatised foods are introduced into the stomach. On testing for peptones, both of these preparations are found to contain them in abundance. They are richer by a good deal, apparently, than the foods which have been acted on by zymine alone, so that it seems as if some of the albumenoids not acted on by zymine have been affected by pepsin, while the peptones already formed have not been interfered with. You will notice that the milk has not curdled.

It would seem from this as if we might expect that the actual food-value of pancreatic peptones would not be seriously interfered with by having to pass through the stomach. Actual experience is, however, a better guide. Dr. Roberts made some experiments with kittens as to the food-value of pancreatised milk. He took four kittens of the same brood, eight weeks old, and fed two on milk and two on milk wholly acted on by pancreatic extract, with the following results :—

No. 1	Fed on milk.
No. 2	Increased 52 and 50 per cent. in weight in 20 days.

No. 3	Fed on pancreatised milk.
No. 4	Increased 55 and 50 per cent. in weight in the same time.

Both sets of animals were equally healthy and lively, and both were equally eager for their food. At the end of the 20 days Nos. 3 and 4 were fed for 10 days on milk partly predigested and Nos. 1 and 2 as before. At the end of that time Nos. 1 and 2 had gained 18 and 26 per cent., while Nos. 3 and 4 had gained 7 and 21 per cent., and had actually lost weight between the third and 5th days. All the kittens, however, remained healthy.

These experiments prove that pancreatised food can be digested in a healthy stomach, and that it is as valuable as ordinary food; but they also show one of the dangers of giving food in such forms. The stomach will do no more work than it is obliged to do, and predigested foods weaken the digestive powers. There are numerous analogous results familiar to us all. Purgative medicines are among the most potent causes of constipation, and the worst thing, as a rule, a man can do for sleeplessness is to take sleeping draughts. Atrophy rapidly follows disuse of functions all over the body. I think it is particularly worth while noting this fact, as it has been claimed for one of these preparations that it is

the only one fit for feeding young infants artificially, and also in other ways its value has, I think, been exaggerated in indigestion. Such claims can only throw discredit on the remedies. I believe that these digestive ferments ought to be placed in the same category as opium and chloral hydrate, or as splints and bandages, only to be used by the physician when necessary, and to be given up as early as possible, or else to be used as opium sometimes is, as the last relief which can be given in incurable cases. It seems to me all the more necessary to recognise this when we see how rapidly any new remedy comes into popular use, and how such drugs as opium, chloral and cocaine have been turned into a curse instead of a blessing to many.

The exact value of these fermented foods must be determined finally by the results of clinical experience, and here it is necessary to speak very cautiously. Indigestion, or malassimilation of food, is a symptom common to all acute and nearly all chronic diseases. It is as often a sign of general tissue enfeeblement, or of merely local gastro-intestinal weakness. Take the gastric catarrh of a drunkard for instance. Here the loathing of food is as much the result of the general poisoning of the tissues by alcohol, and their inability to perform their functions of assimilation, as it is of the mere local catarrh. In chronic dyspepsia of people leading sedentary lives in town, we constantly find that removal to the country, and an open-air life, with plenty of exercise, restores the digestive powers at once. A freer oxidation of tissue takes place, and the first stage of digestion improves as the result of the restoration of the activity of the second stage. The same thing holds good in many other conditions but there are still many diseases in which it is desirable, either temporarily or permanently to assist the gastro-intestinal digestive mechanism.

I have used Pancreatised preparations in the following cases :—

1. Marasmus, probably tubercular, in a boy recovering from typhoid fever.
2. In several cases of gastric ulcer.
3. In several cases of cancer of the stomach, with pyloric obstruction.
4. In several cases of gastro-intestinal catarrh, in infants and adults.

I have also under treatment at present a case of pernicious anaemia, one of cancer of stomach, and one of what I believe to be chronic inflammation of the pancreas, in all of which I am using pancreatised foods. In some of these cases I have also given nutrient pancreatised enemata. The most striking result I have seen was in the case of an infant five months old, who had been

fed on condensed milk. Severe vomiting, diarrhoea, and wasting set in after the administration of some arrowroot. Curdled milk came away in the stools, and the child was evidently in constant pain. After the use of a small enema of warm water, milk, partly predigested with zymine, was given with immediate cessation of all bad symptoms. On resuming ordinary diet in about a week there was a slight relapse, which, however, yielded on the prepared milk being given again for twenty-four hours. None of my other cases were so severe as this, but the same treatment was equally successful with several other children and one adult suffering from gastro-intestinal catarrh.

In gastric ulcer, with one exception, I had good and fairly rapid recoveries, and the prepared foods were well borne. In one fatal case the ulcer was of long standing, and had for its base the pancreas, all the coats of the stomach being destroyed. This patient died at last of perforation in another part of the stomach, but the administration of pancreatised food was followed by marked relief of all his painful symptoms.

In cancer, with pyloric obstruction, I have hitherto used pancreatised preparations, and in the patient at present under treatment there has been a good deal of vomiting, even with these. I feel inclined now to use only acid peptones by the stomach, and to give nutrient pancreatised enemata in all cases where there is any obstruction to the free passage of food from the stomach into the duodenum.

The case of pernicious anaemia has only been a few days under treatment, and I can say nothing of the result. In some cases, at least, of pernicious anaemia, as Dr. Osler has shown, the disease is associated with atrophy of the stomach, and the use of peptones seems a rational treatment. The patient whose case I suspect to be one of pancreatic disease, has apparently been benefitted by the use of pancreatised food. This is a meagre list of cases, but I have thought it better to bring them before you than to cite cases at second hand.

A larger experience of the results of peptonised diet will have to be recorded before we can be certain as to its suitability in various cases. Dr. Roberts quotes cases of vomiting in advanced Bright's disease, which were at once relieved by the use of peptonised milk gruel, and of similar relief or cure in cases of gastric ulcer, pernicious anaemia in its early stage, pyloric and intestinal obstruction, and the crisis of cardiac disease.

A large number of cases in which zymine has been used successfully in the gastro-intestinal catarrh of children is already on record, and I think there can be no doubt that in this preparation we have an excellent means of giving rest for a time to an inflamed or injured intestinal track.

DIABETES INSIPIDUS, TREATED WITH CODEIA.

READ BEFORE THE S. AUSTRALIAN BRANCH, B.M.A.

BY C. E. TODD, M.D.

SOME time ago Dr. Lendon read a paper before this Society upon the use of Codeia in Diabetes Insipidus. His case was so successful that I determined to give the drug a trial when next a case came under my care. Not long ago a man, aged 38, came to consult me. He gave the following history. In February last he was working at his trade as a blacksmith. He worked very hard, and, as the shop was in an exposed place, he felt the changes of temperature very much. He suddenly began to suffer from great nervousness and mental depression, and in a few days he began to pass large quantities of water during the day and night. The polyuria became so troublesome that he was obliged to give up work and seek advice at the Melbourne Hospital, where they told him that he had diabetes insipidus. They did him no good there; and when he came to me he told me that he was quite unable to work, as he had to pass water every few minutes during the day. The amount he passed varied from 19 to 26 oz. It had a specific gravity of 1001, and contained no albumen. He suffered much from thirst, and was very nervous and depressed. I put him upon codeia, and he has been taking it ever since. He still passes a great deal of water of very low specific gravity, but his condition has very much improved. He has less thirst and feels much more lively. He can now hold his water for several hours, and has only to get up twice during the night.

The largest quantity of water that he has passed while taking the codeia is 16 oz., and the smallest $7\frac{1}{2}$ oz. The general average has been 11 oz.

This patient has had no unpleasant symptoms from taking codeia, and he certainly is very much better in appearance than he was before he began the drug. I cannot tell whether the relief will be permanent, but I fear not.

DR. VEROO, in reference to the use of codeia in diabetes, said that the question of the quantity of the drug used was a very important one. Dr. Pavey never gave less than 10 grains, and sometimes even went as high as half-a-drachm. He thought it would be a most valuable thing if members would note the following points in any case that came under their notice. They were—(1) Quantity of urine. (2) Its specific gravity. (3) The amount of sugar. (4) The quantity of codcia given. (5) The diet prescribed.

MR. JAY referred to a case that had been under his

care on the voyage out. The specific gravity of the urine was 1038. The symptoms were well marked. The quantity of codeia given was from half to two grains. The amount of sugar was much lessened, and the specific gravity of the urine brought down to 1020. The diet was vigorously anti-diabetic. The weight of the body increased. Three years after the condition of the patient was much about the same. Whilst under the influence of the drug the patient felt great relief.

A CASE IN WHICH ALARMING SYMPTOMS OF COLLAPSE FOLLOWED IMMEDIATELY UPON ASPIRATORY PUNCTURE OF AN HYDATID OF THE SPLEEN.

By J. DAVIES THOMAS, M.D., LOND.,
OF ADELAIDE, S.A.

MRS. H. T., aged 27, resident in a small township in the south-eastern district of this Colony, consulted me on October 4, 1886, in consequence of an enlargement on the left side of her abdomen.

She was born, and for the greater part of her life has lived, at Mount Pleasant; five-and-a-half years ago she was married, and then lived for two-and-a-half years in Adelaide; since that time she has resided at Lucindale. Although not a vigorous person she states that she has always enjoyed good health, and indeed has suffered from nothing except occasional attacks of migraine. She has never fainted or shown any indications of cardiac weakness. Menstruation has always been normal.

Upon examination, the *right side of the chest* showed nothing abnormal, and the liver was of natural size.

On the *left side*, in the left nipple line, dulness commenced at the margin of the thorax; inside this line there was a tympanitic (stomach) note; in the mid-axillary line dulness at the eighth rib. Abdomen—there is a tumour occupying the left hypochondriac region, and extending downwards to a point about two fingers' breadth above the level of the umbilicus; transversely the lower edge extends nearly to the median line. The tumour decends very obviously during inspiration. There is some protrusion of the left costal arch; this is especially noticeable in the left nipple line. No bulging of lower intercostal spaces. The surface of the tumour below the margin of the thorax is smooth, and neither fluctuation nor hydatid fremitus can be elicited. In the erect posture, the lower border of the tumour occupies a situation

one inch lower than it does in dorsal decubitus. The cardiac apex beat was felt feebly at its normal site; the heart sounds were natural. Posteriorly, dulness commenced at the ninth interspace in the scapular, and continued thence to the lower limit of the thorax.

The diagnosis of hydatid of the spleen was made, and it was determined that an exploratory puncture should be made, partly to establish the diagnosis, partly to ascertain at what depth in the spleen the cyst lay. If it were ascertained by the exploratory puncture that no great thickness of spleen substance intervened between the surface and the cyst, it was my intention to operate by incision. Accordingly, on the morning of October 5, in the presence of Dr. Lendon, I performed an aspiratory puncture with a needle of fine calibre. The needle was a new one, and had been dipped in 5 per cent. carbolic lotion, all fluid being removed by drawing the needle between the finger and thumb immediately before its insertion. The needle was passed slowly and vertically into the most prominent part of the tumour, but when its open end was well below the skin the vacuum was turned on with the object of ascertaining exactly at what depth the cyst lay. At first a small amount of blood passed, but at the depth of one-and-a-half inch clear fluid flowed freely. As it was not my wish to empty the cyst the needle was withdrawn after about three ounces of fluid had been removed.

The patient complained but little of pain at the time, but within five minutes I noticed her face suddenly flush, and she commenced to scratch her face, neck and arms. Over the itching parts were seen erythematous patches, but no distinct wheals of urticaria. Besides the itching, she complained of abdominal pain. In the course of a few minutes her face became dusky, her hands and feet cold, and the radial pulse became imperceptible. Consciousness appeared to be lost, and her general aspect was exactly that of a person in the "algide" stage of cholera. She was to all appearance moribund, and continued so for over three-quarters of an hour. No pulse could be felt at the wrist, the heart beat and sounds were scarcely perceptible, the respiration was hurried and laboured. Hypodermic injections of ether were introduced at short intervals in the right buttock, into both upper limbs, and into the left pectoral muscle, in each case about thirty minims being used. In from 45 to 60 minutes after the onset of the symptoms, and a few minutes after the use of the ether injections, the patient rallied somewhat and spoke. She complained of abdominal pain, and expressed a desire to go to stool. Of course this could not be permitted in her still almost pulseless condition,

but she at once passed two rather liquid motions into cloths arranged for the purpose in the bed. The motions were semi-fluid at first, and then watery, and one of them contained a doubtful trace of blood. Copious watery vomiting also occurred, and the vomiting and diarrhoea were the earliest phenomena of re-action.

The radial pulse was first felt two hours and a-half after the operation, and Dr. Lendon, who was now in charge of the patient, reported that at the end of three hours warmth commenced to return, although the extremities continued cyanotic still. At this time the heart was beating 132 per minute, and both radial pulses were feebly felt. One of the earliest indications of her return to complete consciousness was that she called for drink, and her thirst lasted for several hours. She was rather drowsy, probably in consequence of the ether injections, and the somewhat liberal administration of brandy after she recovered sufficiently to swallow. Five hours after the operation she had rallied considerably, but the radial pulse was still very weak. During the last two hours she had vomited several times, and several motions had been passed; the latter had a particularly offensive smell, and contained doubtful traces of blood and much tenacious mucus; but neither the stools nor the vomited matters contained any trace of hydatid membrane. In the evening the temperature was 102·6; pulse 134. She complained only of pain in the seats of the ether injections.

October 6.—Morning, temperature 100·2; pulse 126. Feels comfortable and has no abdominal pain.

October 7.—Morning, temperature 99; pulse 120. Says that she feels in her usual health and has no abdominal pain or tenderness, but complains of pain at all the sites of the ether injections. The tumour does not extend so far down the abdomen as before the operation by about an inch.

October 9.—Morning, temperature 99·2; pulse 116; weak, no pain, was allowed to leave her bed.

On the ninth day after the puncture the patient called on me and stated that she felt quite well. There was still a tumour to be felt in the left hypochondriac region, but it was smaller than before puncture. She was requested to return in the event of any increase in size of the tumour, and in any case within three months.

The exact site of the puncture was in the Left nipple line, one half-inch below the costal margin.

This case is by no means unique, for in St. Bartholomew's Hospital Reports, Vol. XVI., Appendix, page 30, there is a brief reference to the case of a man, æt. 49, who "died suddenly after paracentesis; the trochar had penetrated a small cyst in the right lobe (of the liver)". There

was also present a large cyst in the liver—this had not been punctured. There was also a large cyst in the spleen; the kidneys were contracted. Apparently this case is cited by Dr. Mansell-Moullin in his article on "Shock," in the International Encyclopædia of Surgery, page 361. Some additional facts are mentioned here, viz., "a fine aspirating trochar and canula were introduced without any anaesthetic, and a few drops of clear fluid evacuated. As no more followed, a canula, somewhat larger, about the size of a small goosequill, was inserted through the same opening immediately on withdrawal of the smaller one. A few drachms of blood-stained fluid came, and then, all of a sudden, the patient's face became pale and livid, his arms sank down by his side, and, with the exception of a few faint irregular beats, the pulse ceased."

Another case, of somewhat similar character, is recorded in the Clinical Society's Transactions, Vol. XI., page 230, by Mr. T. Bryant and Dr. Hilton Fagge. It was that of a man, æt. 40, who had an hydatid of the liver. "Without any anaesthetic, 'a trochar not larger than a silver probe' was passed into an hydatid of the liver, nine ounces of fluid being removed. A few seconds after the operation the patient became intensely flushed, and complained of an agonising pain in his face and jaws. As suddenly as he became flushed he became livid and unconscious, and after vomiting two or three times had a kind of epileptiform seizure from which he never rallied; at the same time his pulse ceased." This patient had suffered four years previously from an epileptiform seizure in which he was unconscious for two-and-a-half hours. In this case it was found that the trochar had transfixated the trunk of the portal vein. Dr. Fagge's hypothesis was that after withdrawal of the trochar, hydatid fluid escaped into the portal vein (was sucked into it), and acted as a direct and fatal poison.

Another case is recorded by Martineau (*Lancet*, August 28, 1875). A man, æt. 31, punctured by a very fine trochar; a small quantity of clear fluid was removed, the patient became faint, vomited, and died in twenty minutes.

In all these cases, except that of Mr. Bryant, it would appear that the dangerous or fatal phenomena were due to shock, and seemed to point to sudden inhibitory influence upon the heart, probably exerted in a reflex manner through the sympathetic supplying the liver or spleen as the case might be. In some rare instances sudden death has followed puncture of pulmonary cysts. Most of these seem to have been due to flooding of the lungs with hydatid fluid, but in a case sent to me by Dr. Holden, of Hobart, it is possible that death resulted from shock.

TUBERCULOSIS.

BY HENRY ALBERT REED, L.R.C.P., Lond.,
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Doubtless many of my medical brethren have from time to time come across cases which they have diagnosed as "Tubercular," and probably have given a bad prognosis of—and yet many of these cases have ultimately recovered, or the symptoms which have caused one to give a bad prognosis have subsequently entirely disappeared. I am speaking of Tuberculosis in children. Now is one to suppose that these cases (1) "are not Tubercular," or that one (2) "has cured the patient," or that there is (3) "still a disease unnamed by the faculty which is so nearly allied to Tuberculosis, and yet not so fatal in its results," or (4) "that Tuberculosis, if treated early, according to our latest knowledge, is curable?"

These thoughts have recently engaged my attention, more particularly as a case has come under my notice in which these points are practically demonstrated, and it is not only because it is an instructive and interesting case, but also to get the opinion of other medical men who are more experienced than I am that I am bold enough to trouble you with this paper. In this hemisphere, and especially amongst us poor medics rusticating in these out-lying districts, we are dependent upon the dissemination of ideas through the pages of your journal, as we are not yet advanced enough to form a society; in fact, "a want of unanimity" is a very, very mild manner of expressing the bearing of the medical brotherhood here in their relationship one to the other.

In the etiology of Tuberculosis we are taught to consider the following:—

1. Health of parents.
2. Climate.
3. Hygienic defects surrounding mode of life.
4. Occupation.
5. Cachexiae after various diseases.
6. Age.

To mention a few well-known details of the above headings—all the books tell us that one parent being diseased will transmit his or her disease to the offspring, and especially will those children be more liable to the hereditary taint who most resemble the parent affected, or, that Tuberculosis will follow a taint which has been syphilitic or scrofulous, or, when the tubercular tendency has

been latent in the parents. Now, with all these doors by which tuberculosis can escape from the stigma of having started "*de novo*," I think we might safely put on one side the effects of family history in all that class of cases to which I am more particularly referring, viz.:—Where, to all appearances, the family history is healthy as regards tuberculosis, and where the symptoms of tuberculosis disappear under treatment, which would be one argument in favor of the curability of this class. Here we have "climate," which in this northern island of New Zealand, ought certainly to be considered the most favourable for cases of tuberculosis, and the nearest approach to that ideal climate which our teaching has taught us to regard as all necessary.

Under hygienic defects I would mention:—

- a. Want of proper nourishment.
- b. Excessive work.
- c. Insufficient rest.
- d. Scarcity of fresh air.

These are old world causes, here the realisation of the wished for—

"Eight hours to work,
Eight hours to play,
Eight hours to sleep, and
Eight bob a day"

do away with them.

The occupation, too (such as the inhalation of irritating particles of matter in certain trades), does not apply here, as the class I refer to is limited to children.

The cachexiae, such as follows in the exanthema, may be a source, but I have not sufficient experience to regard it as of much importance.

Age.—Here we have the one cause given in books, which we find applicable, as the time of childhood is the most common age for the commencement of Tuberculosis. So that in the causes enumerated, in which the family history is healthy, age is the only one which is the connecting link.

Now, in the symptoms of well-marked tubercular mischief—of course, I am writing about Pulmonary Tuberculosis, and I am taking it for granted that all phthisis is tubercular—one cannot go wrong, that is to say, that when the decided subjective physical symptoms are combined with distinct and direct clinical signs, there can be no two opinions about phthisis being present or not; but in children, when one meets with those symptoms which lead one to infer tubercular mischief, and with distinct clinical signs, what is one to infer but phthisis? and if the case recovers from all such symptoms, which diagnosis of the four I have earlier mentioned is left? Before going further, I will just mention the outlines of one case which has lately claimed my attention.

A boy, six years of age, suddenly develops

the premonitory symptoms of grave mischief. His appetite fails, he becomes thin and weak with a slight cough, with complaints of pains in the chest, his cheeks flush on slight exertion, he is feverish at night, and, in fact, there is a gradual deterioration of health without any specific symptoms of disease. This goes on for three or four weeks, when medical aid is called in, and then in addition to the above, there are clinical signs of woody dullness all over the right half of the chest, and temperature of 102.4°.

When I was asked to see the case, I found complete dullness over the front and back of the right half of the chest, with the consequent concurrent symptoms of diminished movement fluttering beneath clavicle and increased resistance on percussion. With the stethoscope I found Bronchophony and Pecteniloquy, with some fine crepitation beneath the clavicle. On the left side of the chest there was some increased resonance and some sibilant rhonchi to be heard. The number of respirations per minute were never quickened beyond 25. The lad was distinctly of the tubercular diathesis, but he comes of a good stock on both sides, and had never previously suffered any serious illness. The diagnosis I made was tubercular deposition in the right pleura, and with the object of getting these tubercles absorbed before they dipped into the pulmonary tissue, I ordered the chest to be rubbed with ung. belladonna and strapped with Emp. bellad., gave tonic medicine, and ordered the usual hygienic treatment with a liberal diet and the inhalation of, at first, creosote, and subsequently, terebene. The case slowly progressed for two months, when he was again examined by another medical man, who gave it as his opinion "that unless he had been told he should never have known there had been anything wrong."

I cannot agree with this opinion, because there were at that time distinct auscultatory signs of old mischief.

But in this interval the temperature soon sank to normal, the cough slowly disappeared, the weight at first increased, but subsequently fell, the perspiration ceased, the pain in the side disappeared, and the dullness slowly passed away, from the apex downwards. But the auscultatory signs increased from fine crepitation to prolonged expiration, with distinct tubular breathing and "cracked pot." When the lad was last seen, his health had improved all round, and the only signs were a little dry cough and prolonged expiration.

Now, the interesting part to me in this case is, was my diagnosis correct? If so, did the treatment that was adopted effect the result? Or, is this result only a temporary amelioration of the disease? Now as to the diagnosis: From the

history, from the pain, from the one side being *only—but completely*—dull, and from the small auscultatory symptoms, I think there can be no question but that it was the pleura that was affected. Because one arrives at this by a process of elimination. What else could it be? Phthisis or pneumonia? It was evidently not the latter; but was it that this was the commencement of phthisis, detected before the pulmonary tissue was affected? And are the subsequent signs of tubular breathing and cracked pot to be accounted for by pulmonary complications? Then again, we are told that phthisis very seldom, if ever, commences in one apex alone, and also that tubercular deposit may occur in the lungs and yet no sound of dullness be given out; yet, if this dullness was due to pulmonary tubercular consolidation, would it clear up so rapidly? And if this was tubercular phthisis, would the complete dullness, showing an extensive tract of tubercular deposition, so quickly disappear with such slight remains? Then again, if this is not phthisis, why should we get tubular breathing, prolonged expiration and "cracked pot"? Now we are told that the first and last of these can always be heard in the chests of children; if that is so, then in children we cannot rely on two very important auscultatory signs. But prolonged expiration is held to be always reliable; many go so far as to diagnose commencing phthisis from that symptom. But what is the pathological condition which produces this sound? We know that the bronchi branch and branch, getting smaller and smaller in calibre in so doing. Now air passing from a larger tube to a smaller one with the same pressure behind, gives out a noise. Hence, inspiration is always normally audible, then, when we get audible expiration, the cause must mean dilatation of the smaller bronchi; but this dilatation may be caused through less pressure outside them, or by a relaxation of their walls. I do not see, therefore, why after any pulmonary trouble, or bronchic trouble, or any illness causing constitutional weakness, this should not ensue, and yet after returning health entirely disappear. So that we need not place so much reliance on this symptom.

From the above, I believe my diagnosis of tubercular deposition in the right pleura was a correct one, and that either through the treatment adopted, or through the health of the child, or the climate, these tubercles were absorbed before spreading into the pulmonary tissue. There are some very interesting points to be raised out of this question, and some very contradictory misleading symptoms to be accounted for in pulmonary tuberculosis of children. That we cannot rely on the same symptoms as in adults I firmly believe, and beyond that, I believe the subject of pulmonary tuberculosis in children has yet to be written.

CASE OF ABDOMINAL TUMOUR.—
OPERATION—RECOVERY.

By H. V. DREW, M.R.C.S., RESIDENT SURGEON TIMARU HOSPITAL (CANTERBURY), NEW ZEALAND.

Mrs. B., aged 50, was admitted on Saturday, 15th January, 1887, suffering from a tumour of the abdomen; she was as big as a woman at about the ninth month of pregnancy.

HISTORY.—She had noticed some enlargement for about a year, but during the last few weeks it had made very great progress. She had suffered a good deal of pain in the abdomen recently, in other respects she was in fairly good health. On the next day, Sunday, having specially prepared a room (quite away from the general wards), by burning sulphur in it all night, and having the floor washed with 1 in 20 carbolic acid lotion, we held a consultation, the result of which was that the operation was fixed for three in the afternoon.

A hypodermic needle was passed into the tumour, and a syringeful of bloody matter was obtained, which under the microscope proved to be altered blood.

I made an incision in the middle line, under chloroform, about six-inches long, and cut carefully down to the peritoneum, opened this on a director, and found the wall of the cyst adherent in front; these adhesions, however, soon gave way, only to reveal stronger ones attached to every organ in contact with the cyst, the liver, intestines, iliac fossæ, in fact it looked very much as though it would be fatal to separate them, some being regular bands, but by working patiently with the soft tip of my finger, not using the nail, they gave way one by one, though at the expense of the serous coat of the bowels.

I may say, that such of the intestines as could be seen were of a pink colour before any manipulation took place. After the cyst was free the usual ligature was put on, viz., strong carbolised silk, and the cyst removed, the pedicle being transfixated. It was found necessary to use the trocar before the deeper adhesions could be reached.

The abdominal cavity was then thoroughly washed out with warm 1 in 60 carbolic lotion, and all fluids sponged out.

The edges of the peritoneum were then brought together with kangaroo tendon, and the skin incision with stout carbolised silk and strapping; iodoform was dusted over the line of incision, and antiseptic wool applied, and a pretty tight flannel roller over all. Morphia suppositories were used during the night, and nothing but ice given by the mouth for the first 24 hours, and for the next few days small nutritive enemata were given, and milk and water to drink; the diet was then gra-

dually increased, and at the end of a month the patient was perfectly well and went home.

The only untoward event was the formation of a little pus, which was drained away by a tube inserted by Dr. Lovegrove, who kindly took charge a few days after the operation, when I was called to Dunedin in the Hall case.

The temperature never rose to 100° F., and after the first few days was normal. My thanks are due to Drs. Lovegrove, Hogg and Reid, for their valuable assistance.

I send this case for publication as it seems to illustrate the amount of injury to the bowels that may be recovered from, even when infected and red before operation.

Every antiseptic precaution was taken, except the use of the spray, and warm carbolic lotion 1 in 60 was used. The room was isolated and sulphured out the evening before the operation, also an even temperature kept up the whole time, i.e., 65° F.

COCAINE DOSAGE AND COCAINE ADDICTION.

READ BEFORE THE KINGS COUNTY MED. SOC., FEB.
15, 1887, AND SPECIALLY COMMUNICATED TO
THE *Australasian Medical Gazette*,

BY J. B. MATTISON, M.D.,
OF BROOKLYN, NEW YORK, U.S.A.

THE sad story of the Russian surgeon's suicide from sorrow or remorse due to his belief that a patient had died from an overdose of cocaine, points a moral, the import of which demands more than a passing notice.

No advent in the therapeutic arena during the last decade, has been attended with such varied and extensive claims for favour as cocaine. Its marvellous effect in ophthalmic surgery roused a spirit of experimental research in other directions which has added largely to its well-proven power for good; but, as has been well observed, a potency for good implies a potency for harm, and the risk impends of its ardent advocates being carried by over-enthusiasm beyond the limit of a safe regard for the welfare of their patients or themselves, that may imperil an otherwise well-founded success.

Surely it is, in the writer's opinion, full time to draw the line; to re-voice a warning as to the use and abuse of this valued, but, at times, toxic drug, lest the roll of alarming, dangerous and fatal effects from its ignorant or incautious using be sadly extended, and a reaction ensue that, by creating distrust within and without the profession, will damage its good repute, and hinder its use in cases where it would be almost certain

of serving us well. And the need of this seems all the more called for in view of opinions expressed, the past year, in certain quarters, affirming the harmless character of cocaine—opinions which, I am convinced, are at variance with well accredited facts, and should not be allowed to pass uncontradicted.

Cocaine seems to have secured for itself a more than usual share of attention aside from the professional press. One metropolitan daily, in particular, has, again and again, given its columns to a discussion of the topic, and in a somewhat lengthy article not long ago, an “eminent but unnamed specialist”—Dr. Francke H. Bosworth—was reported as saying “there is not a well-authenticated case on record, as yet, where cocaine has effected injury.”

In view of cases cited in this paper, and others elsewhere recorded, such a statement is no longer tenable, and any conclusion based thereon as to the harmless nature of cocaine is misleading and incorrect.

And the evidence herewith presented weighs even more heavily against an assertion by Dr. Wm. A. Hammond, at a recent meeting of the New York Neurological Society, in the course of his “Remarks on Cocaine and the so-called Cocaine Habit,” when, after telling his taking of eighteen grains at a subcutaneous dose, he asserted “he did not believe any dose that could be taken was dangerous!” What might be the outcome of such an opinion put in practice? The Russian surgeon’s error of judgment, fatal to his patient and himself, was largely due to his reliance on the asserted use by other surgeons of large doses without ill-effect. Might not a like result follow an incautious dependence on Dr. Hammond’s disbelief in the toxic power of cocaine? The *Record* well said of Prof. Kolomnин’s case: “The experience, though so sad, may not be without its lesson,” and put a very pertinent query as to whether “there are not other surgeons who could report very serious, if not fatal results from injudiciously or ignorantly using too large a dose of cocaine?”

The cases herewith noted, attest a power in this drug on some patients, that warrants caution with all.

“A young woman, aged twenty-three, was sent to Prof. Kolomnин, and found to have a large ulcer of the rectum, which was diagnosed to be of tuberculous nature. He decided to scrape and cauterize the lesion and to use cocaine anaesthesia during the operation.

“In order to produce anaesthesia, he had fifty grammes of a five per cent. solution of hydrochlorate of cocaine prepared: of this, thirty grammes were brought into use, contain-

ing exactly twenty-four Russian grains of the salt, or twenty-three English grains—the Russian grain is exactly one-sixteenth of a gramme—six grains being injected at a time into the rectum. After the third of these injections, it was found on examination that the part was still sensitive. A speculum was then introduced, the ulcer dabbed with a dry sponge, and then the fourth injection given, making twenty-four grains in all. After this the parts were tolerably anaesthetic. The ulcer was scraped, and a tampon saturated with oil inserted. The pulse was then accelerated. During the operation the patient groaned, so that even the twenty-four grains had not produced complete anaesthesia.

“After the operation, Kolomnин went round his ward, and in three-quarters of an hour a message was sent to him that the patient was very low. He found the pulse very weak, the face and hands cyanotic, and the respiration laboured. He considered that she was in a toxic state, and used every means to bring her round, Prof. Sushchinski being also invited to a consultation. Faradization, artificial respiration, hypodermic injection of ether, administration of ammonia, tracheotomy for the inhalation of oxygen, stimulating and nutrient enemata—all were tried, but without success. Kolomnин had no doubt that death was due to cocaine.”

Dr. W. H. Long, U. S. Marine Hospital Service, reports in the *American Lancet*, the case of a man aged thirty-three, to whose larynx he applied, three times, a four per cent. solution of cocaine. Prompt relief was given, but three and one-half hours later the patient was found unconscious; breathing, laboured; respiration, twenty; pulse, ninety; general condition, one of profound anaesthesia. Diagnosis, cocaine poisoning. Several doses of whisky were given subcutaneously. In half-an-hour, consciousness partially restored, then gradual and full improvement save a feeling of great exhaustion.

Four days later cocaine was again used. Thinking the former toxic effect due to swallowing some of the solution, and probable absorption by larynx, extra precaution was taken to have it expelled and the pharynx well rinsed. Two applications of a two per cent. solution were made. Relief was again complete, but three and one-half hours after, patient was in same condition as before, except the anaesthesia not so profound. Frequent injections of whisky were again used with partial success—could swallow and answer questions—but, soon after, he suddenly ceased to breathe. The heart beat a short time longer. All efforts at resuscitation failed. The probable immediate cause of death was paralysis of the respiratory centre due to cocaine.

Dr. F. M. Thomas, Leonardsville, Kansas, reported to Prof. R. Ogden Doremus, as follows:

"Friday morning, October 28th, 1885, I was called to see Mrs. —, aged thirty-nine, whom the messenger reported as dying. I found her unconscious; breathing heavily and irregularly, pulse thirty-five, intermittent; temperature normal; left pupil largely dilated, right natural; right arm and lower limbs motionless; face spasmodically drawn upwards toward the dilated eye.

"Spasmodic action of the left arm and upper part of the body came on regularly at intervals of a few minutes, during which she clutched the bed-clothing, and seemed to be trying to vomit. Twice during my attendance she ejected small portions of the previous evening's meal. Salivation was excessive; retained a dorsal decubitus; would not lie on either side. Heart seemed almost exhausted.

"I saw her at 5 a.m., and was with her nearly all the time till she expired, apparently completely exhausted, about 8.30 a.m."

On inquiry, the Doctor learned that Mrs. — had been freely using a four per cent. solution of cocaine, for toothache due to several much decayed left upper molars. His diagnosis was cocaine poisoning.

Dr. Knabe, of Berlin, records the case of a girl aged eleven, who was given four to twelve drops—the exact amount was not determined—of a four per cent. solution of cocaine, by injection over the deltoid, to remedy frequent fainting fits—she having cardiac degeneration, sequeling scarlatina. In less than forty seconds the girl took a deep breath, became deadly pale and dropped unconscious. One minute later she was dead.

(At this stage Dr. Mattison read the case reported by Dr. W. E. Ramsden Wood, of Stanmore, Sydney, in the *Australasian Medical Gazette* of August, 1886, entitled "An Overdose of Cocaine".)

Myerhausen relates the case of "a girl, twelve years old, in whom two drops of a two per cent. solution were instilled in the conjunctiva four times, at intervals of five to eight minutes. In all, only a little over one-tenth of a grain was administered, of which, certainly, one-half must have been lost through the tears. Immediately after the operation the child commenced to complain of headache, which became more and more severe until it was almost unbearable. Nausea and vomiting persisted through the entire day. The patient was greatly prostrated, stumbled in walking, speech was almost entirely destroyed, as though the tongue were paralyzed. These symptoms of poisoning lasted all through the night, in which no rest was possible, and gradu-

ally disappeared towards the evening of the following day."

Dr. Schwarzbach, of Sydney, in the *Australasian Medical Gazette*, January 1886, reports the case of a lady, who used cocaine, locally, for pain in the eye. She suddenly became very ill; stupor, pallor, slow pulse and cold perspiration. Under wine and strong coffee, recovered in a few hours.

G. Bockl observed alarming effects follow an injection of six drops of a two per cent. solution into the gums. In ten minutes patient became unconscious, with gaze fixed, vision defective and delirium. Nitrite of amyl gave relief.

Drs. Bardet and Meyer, assistants of Dujardin-Beaumetz, anæsthetizing, for experiment, their own skin, observed, half-an-hour after the injections, dilated pupils and comatose symptoms. One of them fell in a state of vertigo, with pallid face and extreme heart weakness. These toxic symptoms followed hypodermic doses, never exceeding one-third of a grain.

Dr. Ziem, of Dantzig, in 1885, reported a case in which a solution applied to the eye caused pallor and embarrassed breathing, and said that, up to that time, seventeen cases had been cited in ophthalmological literature, in which toxic effects followed the use of cocaine. In three, by injection; fourteen applied to the eye. Pallor, giddiness, dyspnoea, malaise, apathy, great prostration, tottering gait, difficulty of speech, mental confusion and extraordinary restlessness were symptoms noted in both strong and feeble men and women.

Dr. Litten, at a meeting of the Berlin Medical Society, November 4, 1885, in a debate on the action of this drug, cautions against its too general use. He said that among other ill-effects known to occur after an injection are attacks of mania, sometimes very violent, which may prove dangerous; and he asserted the various toxic effects, in some individuals, reach such a high degree that actual danger to life seems to threaten the patient. The case next cited is of interest in this regard.

Dr. Robert Newman, of New York, has reported to me the case of a gentleman, aged forty, in whose urethra a physician injected one drachm of a cocaine solution—strength not stated—prior to cutting the meatus. In half a minute, patient's face flushed, he felt a general pricking sensation, followed by a piercing sting in his temple, violent headache and great excitement. Then he became maniacal, and under the delusion that he had been attacked by a robber, sprang from his seat, seized the doctor by the throat and began to beat him. The delirious excitement persisted three hours.

Germane to the subject of acute cocaine toxæmia is that of cocaine addiction—these notes

are preliminary to a more extensive paper on cocaine ineptiety—the existence of which Dr. Hammond denies. He took a half dozen doses, at intervals of one to four days, and says "he acquired no habit." But to argue from that, no danger of addiction, is absurd. Such evidence is worthless. Dr. Hammond might do the same thing with morphia—more, he might take morphia, subcutaneously, daily, for a month or two, without creating a "habit"—albeit its ensnaring power is well admitted—and yet that would not prove its freedom from danger. Not at all; it would merely show his exceptional strength to resist—many, under a like pressure, would surely succumb.

Supporting this opinion, I quote from the last report of Dr. Orpheus Everts—Cincinnati Sanitarium—a gentleman well-known in alienistic circles—which report was kindly sent me after my paper was written—who says: "A distinguished physician, of New York, has recently reported personal experiences tending to discredit the claim that a cocaine habit, corresponding to the morphine habit is acquirable. The judgment of this distinguished physician is based upon the evidence of personal experience, reported by himself, he having failed to acquire the habit, or any especial fondness for the specific effects of the drug, experienced by the hypodermic injection of one, two, three, and finally eighteen grains of the salt, on five or six different occasions in the evening before going to bed.

"But for the great reputation of this physician as an author and observer of facts, this denial would have but little weight. The testimony is both bad and insufficient. Bad, because reported by himself—the testimony of an intoxicated person respecting his experiences while intoxicated being proverbially untrustworthy—and insufficient, because the experiment was not continued long enough. Many instances might be cited of total failure to establish the morphine habit or habitual drunkenness, by the use of six or seven doses of morphine, or six or seven drinks of whisky, one a day for six or seven days in succession. It is often the case that such experiences end with disgust for the drugs used, instead of a desire to continue their use. There is also much and accumulating testimony, by competent observers, to the fact of such a habit as is alleged, respecting cocaine, which a single opinion will not invalidate, however worthy of consideration."

Cocainism is not the outcome of using the drug at long intervals. Its transient effect and the demand of an impaired nerve status compel frequent taking—more than alcohol or opium—so that habitués have been known to take it ten, twenty or more times daily, and it is this—growing

by what it feeds on—that tends to create and continue the disease.

In the early days of chloral, one point claimed in its favour was a freedom from risk of "habit," a claim long ago exploded, as cases of chloralism well prove, and yet, I venture to assert, there are more cases of cocaine taking in this country to-day, less than three years since its arrival, than of chloral after a period more than six times as long.

Dr. Hammond says there may be instances of cocainism as rare as chronic tea-taking, and of cases with or after habitual alcohol or opium using, but, as for quitting the drug, he believes every cocaine taker could if he would.

The same opinion regarding opium obtains among some medical men, and the only effective argument against such a fallacy is to place those who hold it under power of that drug, and then have them prove their precept by their practice.

While admitting that most instances of cocaine taking are, for obvious reasons, in those who have been, or are, alcohol or opium habitués, especially the latter, I maintain there are cases of pure, primary addiction, and that the number is increasing, at home and abroad. Foreign writers have noted them, and they will figure in our records.

My experience with a number of cocaine cases makes to me two things certain—there is a pernicious power *per se* in this drug, and it finds in the opium habitué a peculiar condition that specially favours its ill effects, making it, for such patients, as has well been said, the "Devil's own device" to still further enslave.

And this opinion is that of others, for it is the testimony, without exception, so far as I know, of those who have had to do with this disease, that as an intoxicant, cocaine is more dangerous than alcohol or opium, and that ineptiety resulting from its use is more marked and unyielding than any other form.

Dr. Shrady, editorial, *Medical Record*, November 28th, 1885—says: "To some persons nothing is more fascinating than indulgence in cocaine. It relieves the sense of exhaustion, dispels mental depression and produces a delicious sense of exhilaration and well-being. The after-effects are at first slight, almost imperceptible, but continual indulgence finally creates a craving which must be satisfied; the individual then becomes nervous, tremulous, sleepless, without appetite, and he is at last reduced to a condition of pitiable neurasthenia."

Dr. Alex. B. Shaw, Physician to St. Vincent Asylum for the Insane, St. Louis, asserts: "Once a man flies to cocaine for relief from 'cares that annoy,' he generally continues with

such rapid strides towards such complete subjugation to its bewitching thralldom as but few will ever be rescued from by any power of will which they may be able to bring to their aid."

Dr. Everts writes: "It is not only not an antidote to opium poisoning—or, more properly speaking, the organic demand for such drug effects as have been acquired by use—but is itself a fascinating and dangerous intoxicant, the effects of which may be more difficult to counteract and renounce than are those of opium or its derivatives."

Dr. Hughes declares it "a remedy to be used with extreme caution and prudence internally, and the large doses reported as having been given are not ordinarily safe. It will bear watching. It crazes and kills quicker than opium. The possibilities for immediate harm are not only great, but the likelihood of remote damage when tolerance is established is not small. The cocaine habit, more pernicious than the morphine neurosis, is the certain entailment of its frequent administration, and its thralldom is far more tyrannical than the slavery of opium."

Erlenmeyer calls cocaine the third scourge of humanity—alcohol and opium being the first and second—and Erlenmeyer is right as to toxic neuroses. He says: "Its characteristic effects are vaso-motor paralysis, accelerated pulse, profuse sweats, dyspnoea and syncope, failure of general nutrition, eyes sunken, skin cadaveric, with mental trouble that sometimes needs restraint," and I am positive, from cases under my care, that he is correct.

I think it, for many, notably the large and enlarging number of opium and alcohol habitués, the most fascinating and seductive, dangerous and destructive drug extant; and while admitting its great value in various disordered conditions, earnestly warn all against its careless giving in these cases, and especially insist on the great danger of self-injecting, a course almost certain to entail added ill. To the man who has gone down under opium, and who thinks of taking to cocaine in hope of being lifted out of the mire, I would say "don't," lest he sink the deeper. I have yet to learn of a single instance in which such an effort reached success; but I know many cases where failure followed, or, worse, cocaine or coca-morphia addiction. And the need of caution against free and frequent using obtains in other cases, for there may come a demand for continued taking that will not be denied.

To summarize: Cocaine may be toxic, sometimes deadly in large doses.

It may give rise to dangerous or even fatal symptoms in doses usually deemed safe.

The danger, near and remote, is greatest when

given under the skin.

It may produce a diseased condition—in which the will is prostrate and the patient powerless—a true toxic neurosis, more marked and less hopeful than that from alcohol or opium.

Such being my belief, I regard Dr. Hammond's statements mistaken, and his conclusions rash and dangerous.

(Besides the cases given, Dr. Mattison relates particulars of upwards of thirty similar ones, of a very suggestive and interesting nature, which, we regret, cannot be published in this issue, owing to extreme pressure on our space.—ED. A.M.G.)

COMPLETE INVERSION OF THE UTERUS.

By W. J. BARKAS, L.R.C.P. LOND. ; M.R.C.S.

In the *British Medical Journal* of March 5th, I notice a short paper on a case of complete inversion of the uterus, in which a case of complete inversion is described so exactly similar to one I attended in February last, that I am induced to forward a brief report concerning it.

On February 7th I was sent for in great haste to attend a Mrs. _____, who had just been confined by a midwife (?), and was informed that there was something wrong with the patient. On arrival at the house I found that the baby was born, and had been properly severed from the mother; but it was stated that the afterbirth was still undelivered. On proceeding to make an examination of the patient, I discovered that the womb was lying on the bed completely inverted, with the placenta rather firmly attached at the fundus. There had been little or no loss of blood, and the patient apparently suffered only slightly from shock. The mishap, I was told, was the result of the midwife trying to get the placenta away by pulling at the cord. I proceeded to carefully detach the placenta, which process was unattended with any haemorrhage; then, by careful manipulation, I gradually restored the womb to its natural condition, and it was done with apparently little irritation, as it caused hardly any pain to the patient, nor did any haemorrhage occur, either then or afterwards, nor did any other trouble arise.

I ordered complete rest and syringing freely with diluted Condy's Fluid. Every day the patient continued improving. There was not the slightest symptom of inflammatory mischief, and lactation was perfect. After confinement to the recumbent position for six weeks or more she completely recovered, the womb being similar, at that time, to a womb that had never been inverted.

Paddington (Sydney), April, 1887.

**A CASE OF STOMATITIS WITH
JAUNDICE.**

By F. H. QUAIFE, M.D.

SEVERAL years ago I saw, within a few weeks, a number of cases of stomatitis in children, which affected several in one family, and appeared to be contagious. The symptoms were those of superficial inflammation of the mucous membrane, viz., deep redness of the whole mouth, extending down into the throat as far as could be seen by ordinary means, with great sensitiveness to touch, or heat or cold, so that swallowing was dreaded. There was a good deal of increased secretion from all the glands of the mouth, and often enlargement of the submaxillary and sublingual glands ; and there were numerous thrush-like white points on the insides of the cheeks and the tonsils. I do not recollect any decided swelling of the last-mentioned glands. There was generally a good deal of fever present, and these symptoms all lasted about a week, and in all the children ended in recovery. During this time I was called to see an old lady, of thin and spare habit, for sore throat, and on examination found a precisely similar state to that described above : there was a good deal of fever, and in this case, diarrhoea and great thirst. The soreness of the mouth and pain on swallowing, with the feverishness, alarmed the patient, and her husband and I cheered her up with good hopes that nothing serious would ensue, but, unfortunately, I was too sanguine. The diarrhoea, which had been in existence for some days before I saw the patient, proved intractable, and while the mouth and throat improved, soon jaundice appeared, and in a very few days the old lady sank and died. I prevailed on the husband to let me examine the alimentary tract, and I found that the inflammation extended from the mouth down into the ileum, and was very marked in the duodenum, and on opening the liver and tracing up the ducts from their outlet, the lining membrane of these was found to be swollen and highly congested as far as could be observed. The thrushy appearances in the mouth were well marked, but I do not recollect any such appearances in the bowel, or in the ducts of the liver. A few cases of a similar affection to the above have occurred recently (last year) in children, but not to near so great an extent as at the time referred to. I think there can be no doubt that in the fatal case the mischief began as the same mouth affection as in the children, and that, owing to age and want of the

resisting power of youth, it spread rapidly along the alimentary canal. In none of these cases was there any affection of the chest, nor were there laryngeal signs, either spasmody or inflammatory.

Woollahra, Sydney, April, 1887.

**A CASE OF ACUTE YELLOW ATROPHY
OF THE LIVER.**

By F. W. ELSNER, F.R.C.S.I.

THE following case of this rare affection occurred in Collingwood, a suburb of Melbourne, in the last week of May, and may be taken as a most typical example of the disease.

Mrs. T., set. 26, was married for the second time five months ago, and became pregnant a month later, for the first time, so that she was in the middle of her fourth month when the disease first made its appearance. On Tuesday, the 24th of May, she was seized with pains in the right side, feverishness, and vomiting, and at once became jaundiced. On Wednesday she had pains all over the body, and became greatly depressed, whilst the vomit gradually became darker, until, on Thursday, it became quite black, and of the typical "coffee-grounds" character. No notice was taken of her symptoms by her relatives until late on Thursday night, when she became delirious, and fell out of bed. I was then sent for, and saw her at 4 a.m. on Friday morning, the 27th, when her condition was as follows :—Breathing laboured, face flushed and conjunctive very yellow, skin not so badly tinged ; temperature, 100·4 ; pulse, 80 ; patient delirious at times and semi-comatose, but showed her tongue after some little persuasion ; it was intensely red, but not furred ; vomiting and eructation of flatus continuous ; the vomit was altogether "coffee-grounds," there was obstinate constipation, but urine was voided involuntarily, and stained everything it came in contact with a deep yellow ochre colour ; tenderness all over the abdomen ; meteorism ; *line of hepatic dulness about one inch deep under the line of the attachments of the diaphragm to the ribs* ; splenic dulness increased. I ordered a bismuth mixture, a large injection, and 5 grs. each of bismuth and calomel in a powder, to be taken at once, but on returning at noon to see the patient I had reason to believe that very little treatment had been carried out. A nurse was advocated, and, having made my diagnosis, I urged the necessity for an immediate consultation,

as the patient was now completely comatose and kept her teeth tightly clenched, groaning continuously the while. In the afternoon, Dr. J. P. Ryan was called in, but not informed that I was in attendance, and he at once gave the most serious prognosis. When I, on Saturday morning, again saw the patient I was not informed of Dr. Ryan's being in attendance, and again urged the gravity of the case and the necessity for more advice; I was told that when Mrs. T.'s mother arrived I would be notified of the relatives' intentions, but received no such notification. In answer to a message I sent, I was desired to come at once, whereupon I took Dr. Jamieson with me and we at once examined the case thoroughly, drawing off by the catheter a half-pint of urine of a fearful odour and the colour of muddy ale, the results of the examination of which I append to this report. We found the patient comatose and breathing stertorously, the face flushed, the eyes suffused, pupils insensible to light; general jaundice, but not intense; pulse, 104; T., 102; *no line of hepatic dulness discernible on percussion*; meteorism; tonic spasm of the muscles of the extremities; a coloured discharge from the vagina, but no urine voided spontaneously now. The patient had only one motion for two days; it was drab-coloured and offensive. No medicine or food of any description had been administered per rectum or otherwise for two days, for some unexplained reason. There had been convulsions, and the patient's bed and night dress were saturated with black vomit, which would sometimes gurgle up through her closed teeth as she lay on her back comatose—a truly pitiable object. Diagnosis: acute yellow atrophy of the liver and consecutive effusion into the ventricles of the brain, the prognosis, of course, hopeless.

Dr. Jamieson and I were then informed that Drs. Moore and J. P. Ryan were waiting to consult with us; they examined the patient subsequently and came to the conclusion that the case was hopeless, and found the same condition of affairs as just described. Dr. Ryan's opinion was that it was a case of "malignant jaundice with effusion," which opinion was of course endorsed, as it stated the facts, but this would not furnish the cause of the jaundice which alone could never be aught but a symptom of hepatic mischief. Luckily the examination of the specimen of urine which I was able to secure has most satisfactorily settled the question as to the diagnosis of a most interesting case, and which, by a curious combination of circumstances, four medical practitioners were able to see at the same time, a majority agreeing as to the cause which could be established without the aid of a *post-mortem*. Death

took place at 20 minutes to 10, without any amelioration or aggravation of the symptoms, on the 28th of May, after 4 days illness, so that fulminancy would be another point in favour of the diagnosis of "acute atrophy."

I examined the urine the same night and found satisfactory evidence of the presence of leucin and tyrosin in large quantities; lest error might have crept in I took the specimen of urine into Mr. Cosmo Newbery's laboratory on Monday, 30th May, and his assistant, Mr. Stone, very kindly verified the following results: Sp. g. 1,030; colour, dark reddish-brown; abundant sediment; albumen present in large quantities, as also leucin and tyrosin; these bodies are found in conjunction in organic disease in any quantity, namely acute yellow atrophy of the liver (Radziejewsky in Archiv f. pathol. Anatomie, bd. 36, p. 1, also Zeitschrift f. anat. Chemie, bd. 5, p. 466). Leucin though found normally in some parts of the body, is never found in the urine dissociated from tyrosin in acute yellow atrophy.*

Microscopically the most perfect crystals were obtained after evaporation with H.N.O₃ and N.H₄ of nitrate of nitro-tyrosin, needles of snowy whiteness gathered into bunches like sheaves of wheat.

Evaporated on the platinum spatula, with H.N.O₃, the characteristic pumpkin-colour was obtained of tyrosin, and when evaporated with H₂ to , this residue, treated with caustic potash, gave the characteristic reaction for leucin; it became converted into an oily substance over the flame, which would not adhere to the platinum, but rolled about like mercury.

The most concise test is this: An absolutely pure solution of leucin will not be precipitated by a solution of mercurous nitrate, whereas if the solution be contaminated by the presence of tyrosin a precipitate will be thrown down, whilst the supernatant fluid will become a pale rose-colour, or dark red rose-colour on standing for a little while. This characteristic reaction was obtained again and again in the urine of Mrs. T., so that all the points necessary for the establishment of the diagnosis have been found.

Church Street, Richmond (Melbourne),
May 30, 1887.

* Mr. Stone, Mr. Cosmo Newbery's assistant at the Melbourne Technological Laboratory, has since I saw him, carried on further investigations with the urine I left him, and succeeded in isolating leucin by adding acetate of lead, filtering, passing through the solution a current of Sulphuretted Hydrogen, filtering again, evaporating down the filtrate and extracting the leucin with boiling alcohol. This gave a nearly colourless solution, the residue of which, under the microscope, showed the characteristic oil-globules of leucin. An alkaline solution of the residue of the alcoholic solution gave no precipitate with a solution of sulphate of copper, which is a very reliable chemical test. The importance of this confirmation cannot be over-estimated.

POST-NASAL VEGETATIONS.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH,
B.M.A.

By W. ANSTEY GILES, M.B. EDIN., LECTURER
ON AURAL SURGERY IN THE UNIVERSITY OF
ADELAIDE, AND ASSISTANT SURGEON TO
ADELAIDE HOSPITAL.

IT is not my intention to go fully into this subject to-night, but I wish to make some remarks especially referring to the treatment, exemplified by two satisfactory cases. The tendency of these growths is to disappear after the age of 14 or 15 is reached, but in the interval so much harm may be done by setting up chronic changes in the mucous membrane of the throat, nose, and ear, that their early removal, in as complete a manner as possible, is most urgently called for. Various methods of operating have been recommended by the numerous writers on the subject. Injections of alkaline lotions through the nostrils, or salt and water used in the same way for a lengthened period, have caused the growths to gradually dry up. Solid nitrate of silver, applied directly, has effected a cure in the hands of some writers. The galvano cautery is lauded by others who have found it answer all requirements.

Meyer, of Copenhagen (who will always be recognised as the first man who carefully studied and wrote upon the pathology, symptoms, and treatment of this affection), operates with a ring knife, which he introduces through the nostrils, and by this means the tumours are cut off. The knife is guided by the index finger of the left hand, passed up behind the soft palate. When all growths are removed, he washes out the cavity with a saline solution, and cauterises the walls with solid nitrate of silver. He can operate on young children, in the sitting position, without an anaesthetic by this means, with perfect satisfaction and success. A week after the operation he commences the after treatment, which he considers of the very greatest importance to prevent a recurrence of the vegetations. This consists in cauterisation with solid nitrate of silver, and douches with alkaline lotion twice a day until all soft and bleeding remains of the growths have disappeared.

Guye, of Amsterdam, who has given us some valuable contributions on the subject, always uses his index finger to crush the soft, friable vegeta-

tions, and scrapes everything away with his nail.

Sir William Dalby has a steel nail made to fit the index finger, and with this he can remove all growths easily and completely.

Löwenberg, of Paris, has devised a pair of forceps which he passes up behind the soft palate, and with these can very thoroughly clear the whole space of the abnormal growths.

Woakes, of London, has modified Löwenberg's forceps somewhat, and in his monograph before the International Congress of 1881, as well as in his book on "Post-Nasal Catarrh," he treats the subject in an able and exhaustive manner. Having briefly alluded to the methods of treatment advocated by some authorities, I will give an account of the two cases I wish to report upon.

Case I.—A healthy boy, *æt.* about 4 years, living in the country, was brought by his mother, who complained that he could not breathe through his nose, that his respirations were always noisy, that he snored loudly when asleep, and that his speech was very thick. Dr. Gardner had removed the tonsils a year ago, which were very greatly enlarged, and discovered the growths in the naso-pharynx at the same time. The bridge of his nose was thick and flat, his mouth always open, his lower lip hung down, giving a vacant expression to his face, and a great deal of secretion was constantly coming from the nose and running down the throat.

On the 11th November, 1886, he was put under ether, and while his shoulders were propped up by pillows, his head was allowed to hang well over the end of the table. This position rendered the naso-pharynx very easily accessible, and on passing the finger up, the numerous growths could be felt. They filled the whole cavity, and were within $\frac{1}{2}$ -inch of the free edge of the soft palate, completely blocking the posterior nares. A Mason's gag was inserted to keep the mouth well open. The instrument employed was Woakes' modification of Löwenberg's forceps, and the index finger of the left hand was pushed into the naso-pharynx to act as a guide. With the forceps the growths were one by one removed, until the cavity was almost completely clear. Small sessile tumours remained, and also ragged pieces of mucous membrane, which were carefully scraped away with Meyer's ring knife, introduced through the nostrils. No caustic was used. The hemorrhage was very profuse, but escaped freely through the nose, and as soon as the operation was completed, stopped. No after treatment was employed, and the child has been perfectly comfortable since he was subjected to the process above described. A few days ago the father wrote, expressing his thanks for the successful treatment to which his child had been subjected,

and saying none of the old symptoms had reappeared. His own words were, "My grateful thanks for restoring my little son to ease and comfort."

Case II.—A girl, *æt.* 6, who had suffered discomfort from these growths for some years, and the obstruction to the nasal respiration and snoring were becoming markedly worse.

On 21st December last I operated in exactly the same way as in the first case. The vegetations were not so numerous, but still present in large numbers. The operation afforded immediate relief, and the other day I heard that the child was quite well and comfortable.

Remarks.—The diagnosis was made in both instances by palpation, and the sensation imparted to the examining finger would be well described, by the simile so often employed, "like a bunch of worms." Posterior rhinoscopy is most useful and necessary when it can be carried out. It might be as well to warn those whose fingers are unaccustomed to explore this space, to be careful not to grasp the posterior lip of the eustachian orifice, as this in the first case described, was very much swollen and projected outwards, simulating one of the abnormal growths. The pharyngeal tonsil is usually hypertrophied, sometimes to a very considerable extent, feeling like a large soft cushion in the roof of the naso-pharynx. This should be removed in the same way as the vegetations.

In young children—and it is in them the operation is urgently called for, before the eustachian tube and middle ear have suffered by the irritation which these tumours set up—an anaesthetic is necessary for the complete and thorough removal of these growths at one sitting. If not employed, 4 or 5 sittings or more are required, and I cannot think even then the removal can be so successfully and satisfactorily carried out. When the child is under an anaesthetic, and is placed in the recumbent position with the head hanging down over the end of the table, the soft palate falls forward rendering the naso-pharynx easy of access, and the operation can be performed more speedily and effectually than under any other conditions. The haemorrhage, which is very severe, can continue without the trouble of sponging, for it runs freely out of the nostrils, and there is also no danger of blood passing into the larynx. I think those who try this position will find it add greatly to the ease and comfort of the operator. Writers generally describe the operation to be performed with the child sitting up, a gag in its mouth, and an assistant holding its head, which position, I feel certain, vastly increases the difficulty of the procedure.

REPORTS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY Meeting, held at the Adelaide Hospital, March 31, 1887.

Present:—The President (Dr. Verco), Prof. Watson, Drs. Cawley, Gardner, Lendon, Poulton, Symons; Messrs. Atkinson, Clindening, Finniess, Giles, Jay, Lloyd, Vaughan, and the Hon. Sec. (Mr. Cleland).

The minutes of the meeting held February 24, 1887, were read and confirmed.

EXHIBITS.

Dr. Gardner exhibited a patient who had been suffering from a fungating testicle. This had been replaced and covered over by the scrotum after a free dissection. Complete healing.

Dr. Poulton made the following observations respecting the water-supply, &c.:

SOME OBSERVATIONS ON THE WATER-SUPPLY OF ADELAIDE. BY B. POULTON, M.D.

Dr. Poulton said he had prepared no written paper, but with the permission of the President would make a few remarks on the surroundings of the Hope Valley Reservoir, as illustrated by a rough sketch-map he had made, and would exhibit.

He wished to draw the attention of the members especially to the probability of the water in this reservoir being contaminated by effete human and other animal products, both by surface drainage and also by deeper percolation through the subsoil.

He showed by the map that the catchment area of the reservoir was traversed by two roads open to general traffic, and that it contained a quantity of land alienated from the state, and presumably beyond the control of the Water Department.

He indicated on the map the approximate sites of five habitations, all in the catchment area of the reservoir, one of these being the official caretaker's; and one which he thought was within one hundred yards of the water was also remarkable from its peculiarly dirty surroundings and primitive cow sheds. He remarked that there was no apparent outlet for drainage from any of the houses mentioned, except towards the water in the reservoir; he was not aware that flood waters had actually, at any time, swept over the ground since the establishment of the dam, but he was so much convinced of such an occurrence being probable after continued heavy rain, and the certainty of ultimate soil pollution, that he thought the matter worth the attention of members.

It was carried that the President of the Branch should communicate with the President of the Central Board of Health on the matter.

Dr. J. H. S. Finniess then read a paper on "Puerperal Eclampsia, treated by hypodermic injections of nitrate of pilocarpine," and Dr. Gardner read notes on a "Case of Hydatid Cyst eroding Walls of Subclavian Artery."

It was proposed and carried that Mr. Hayward should be the representative member on the general committee of the British Medical Association, advantage being taken of his projected trip to England.

MONTHLY Meeting, held at the Adelaide Hospital, April 28, 1887.

Present:—The President (Dr. Verco), Drs. Gardner, Lendon, Mackintosh, Mitchell, Poulton, Symons, Thomas, Messrs. Aitken, Bickle, Clindening, Finniess, Giles, A. A. Hamilton, Horneck, Jay, Lloyd, Vaughan,

and the Hon. Sec. (Mr. Cleland).

The President read the following letter from the President of the Central Board of Health :—

"After our conversation yesterday, I looked up the minutes referring to the farm and house near the Hope Valley Reservoir. I find our inspector reported an inspection on 8th November, 1884. At that time the place was in a filthy condition, and the privy cesspool was in a foul state and badly constructed. The Board compelled the owner to construct a new cesspool, and to adopt measures to keep the premises continually clean. The Board's orders were complied with, but owing to the proximity of the reservoir, the attention of the Hydraulic Engineer was called to the danger that might arise from pollution of the water. This lead to an inquiry, and to an inspection by the Hydraulic Engineer. The result was that Mr. Mestayer reported that he was satisfied that no pollution of the water had occurred. He thought it desirable that the farm should not exist so near the reservoir, but the Waterworks Act gives no power to interfere unless actual contamination of the water can be proved. The place has since been constantly under supervision, and in a conversation yesterday with the Hydraulic Engineer, he told me that he has visited the site frequently in wet as well as dry weather. The land is ploughed, and sandy, and the house is about 400 feet from the water. He is still satisfied that no impure drainage passes into the reservoir. The Hydraulic Department want to purchase the land so as to get control, but there have been legal difficulties in the way of completing the negotiations, which have been going on for some months. These are now in a fair way of being removed, and Mr. Mestayer hopes in a short time to get possession. At the Superintendent's house an earth closet is in use, and there is no cesspool."

The President informed the meeting that the council approved of the idea of the medical students being admitted to the meetings as visitors.

Dr. Davies Thomas, seconded by Dr. Jay, then moved that at future meetings permission to attend be granted to the students; this was unanimously carried.

EXHIBITS.

Supernumerary Tooth.—Dr. Bickle, of Mount Barker, showed a tooth which he had removed from the centre of the hard palate of a boy of 11 years of age. The tooth was very pointed, and the sharp point was injuring the tongue and causing an impediment in the speech. In form, although evidently belonging to the milk set, it was neither like an incisor or canine (all of which were present in their proper places), the crown was cone shaped, the apex pointed and twisted to the extent of a half turn, the enamel covering was very thick. It gave no trouble in removal, and had one long conical fang.

Papilloma of Uvula.—This specimen was shown by Dr. Bickle on account of the rarity of a growth of this nature in this situation. He had removed it from a woman about 40 years of age, who consulted him for persistent cough, especially at night. On examining the throat a small pedunculated growth was seen arising from the apex of the uvula and inclining to the right. Removal was advised, but two months elapsed before the advice was adopted. On examining the body it was found to be hard and leathery in texture, and presenting to the naked eye characters of a papilloma. Immediate relief from the cough followed, but lasted only a few days, the patient having contracted cold by foolish exposure, and the throat had become relaxed.

Abdominal Tumour.—The subject of this growth, a girl of 11, was shown by Dr. Bickle. The patient had been brought to him in March by her mother, and the child was supposed to have ruptured herself. On ex-

amination, a tumour about the size of an orange was found exhibited immediately above the pubes. There was some mobility and no bladder trouble, but some pain in defaecation. Occasional attacks of pain were complained of. The child had been getting thinner, and had lost appetite. Although firm the tumour gave a sense of fluctuation, but no distinct thrill was present. Under vegetable tonics the child's general health had improved, but as the tumour had begun to grow perceptably, and operative measures were indicated, Dr. Bickle thought it would be of interest to show it first. His own idea was that it was a hydatid cyst. He had found by relaxing the recti, that the tumour could be pushed freely about the abdomen. The opinion of the members present coincided with that already expressed by Dr. Bickle. No pedicle or deep attachments could be made out. The result and methods used will be communicated at a future meeting if the parents will consent to operative interference.

Dr. Symons showed a case of primary opacity of the cornea.—The patient, a bootmaker, is aged 51, but appears to be much older. There was failure of vision during the past ten months, without pain, redness, or irritability of the eyes. The cornea showed no signs of ulceration, and no lead lotion had been used. The opacity extended horizontally across each cornea—spindle-shaped, occupying the more exposed part. There was no loss of lustre, or break of continuity of the external epithelial covering. A well-marked arcus senilis accompanied the opacity in each eye. The irides only partially responded to atropine. The absence of any gouty or rheumatic history, the habitual scanty dietary, and the evidence of early senility are points of interest in this case.

Dr. W. L. Cleland then read a paper on "Insanity during Pregnancy"; Dr. A. A. Hamilton, a paper on "Tumour of the Brain," and Dr. J. C. Verco, on "Aneurism of left middle Cerebral Artery." The manuscript of these papers reached us too late for insertion into this month's issue; however, they shall appear in the July number, if possible.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 63rd General Meeting was held in the Royal Society's Room, Sydney, on Friday, June 3, 1887, at 8.15 p.m.

Present:—The Hon. Dr. Creed, President, in the chair; Drs. Chambers, Watson, Hankins, Chisholm, Maher, Fiaschi, Pockley, Faithfull, West, McCormick, Twynam, Clay, Fisher, Collingwood, Worrall, Brady, Garrett, Sydney Jones, Kendall, and Scot Skirving.

Visitors: Drs. Huxtable, Cathcart, McDonald and Nagel.

A paper on a case of Landry's paralysis (paralysis ascendens acuta) by Dr. Jarvie Hood, of Maclean, Clarence River, was read by G. T. Hankins, Esq.

Some notes on a case of aphasia, following fractured base of the skull, by Dr. Asher, of Lithgow, were read by Dr. Twynam.

Dr. Scot Skirving read some notes on obstruction of Stenson's duct and alteration of parotid secretion.

Dr. Worrall and Mr. G. T. Hankins made a few remarks upon this case, after which Dr. Skirving replied.

The President announced the following new members: Dr. Wood, Stanmore, Dr. Reddall, Randwick, and Dr. Munro, Glebe.

A motion relating to the milk supply and inspection of dairies was postponed until next meeting.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which is found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JUNE 15, 1887.

EDITORIALS.

BREACHES OF THE VACCINATION ACT IN VICTORIA.

New prosecutions continue to occur in Victoria in relation to children vaccinated with calf lymph by Mr. Graham Mitchell, veterinary surgeon and pharmaceutical chemist, of Melbourne. We think these prosecutions unwise and impolitic, for there can be no doubt that in the majority, if not in all the cases, the children vaccinated by him have been efficiently operated on, and are properly protected against variola.

The hardship to the parents is the greater, because Mr. Mitchell vaccinated the children with the countenance of the government. The operation is simple enough, and might be done effectively by any old woman; the reason why it is advisable that it should only be performed by a properly educated medical practitioner is not that it cannot be done by others, but that the person who does it should be qualified to judge whether the child is in a fit state of health for it being done advantageously, and that he may know whether the created disease has run a due course, and thus afforded proper protection. Though in ninety-nine cases out of a hundred it is possible for a medical practitioner to decide as to the effectiveness of the protection by the inspection of the subsequent scars, yet we do not consider such certificates entirely satisfactory, and deprecate their being given.

We think that the decision of the Prahran Bench, in the case of George Yeomans, is likely to be upset on the appeal to the Supreme Court, for we think that the wording of the 14th section of the Vaccination Act admits of certificates such as that given by Mr. L. L. Smith in the case. We think, however, that the clause should be altered by fresh legislation, and though we consider the prosecution of the parents of children hitherto vaccinated by Mr. Mitchell un-

necessary, we would not allow him to continue his independent action in the matter, we would have no objection to his performing the merely mechanical portion of the proceeding, but we should insist that it should be done under the supervision of a properly qualified medical practitioner, who would decide as to the health of the child, and who, by personal supervision, could certify that the vesicles had gone through a due course.

We hold these views notwithstanding the expressed opinion of the Crown law officers of Victoria to the contrary.

THE CASE OF CONSPIRACY AGAINST A MEDICAL PRACTITIONER IN SYDNEY.

On Friday, May 27, was enacted the last scene in a drama which has been of the utmost interest to the medical profession in Australasia. We refer to the conviction of the men Smith and Marjoram, and the woman Thomas, of conspiracy to extort money from Dr. Wright, of Sydney, by falsely accusing him of having committed a criminal assault upon the female prisoner. The jury promptly brought in a verdict of guilty against all the prisoners, and the presiding judge passed on the two men the highest sentence, provided by the Act, of fourteen years penal servitude. The woman, in consideration of her youth, and of her probably having been a tool of the others, was let off with the comparatively light sentence of five years.

Dr. Wright, from the day the first account appeared in the newspapers, has received the sympathy not only of the profession but of the public, and it has been felt that at great personal sacrifice he has performed an eminent public service by carrying out the prosecution of such vampires. The judge in passing sentence, justly said that the prisoners had been convicted "of the most fearful crime that any person could be found guilty of." The charge is one to which members of the profession are peculiarly liable to be the victims, and it has been made many times against medical men before, though every man who has been charged has not been so fortunate as Dr. Wright, in being able, not only to disprove the charge against himself, but to convict the conspirators. No doubt there are many innocent men who have had to pay heavily to avoid social and pecuniary ruin, in fact, it is generally rumoured that Dr. Wright was not the first victim of these ruffians, but that a civil servant of some standing was mulcted in a couple of hundred pounds to escape exposure, in his case probably more or less deserved.

INTERCOLONIAL MEDICAL CONGRESS,
Adelaide, Aug.-Sept., 1887.

In our issue for March last, we informed our readers that the New South Wales and South Australian Governments had promised to reduce their fares to members of the Congress by one-half, provided the authorities in Victoria would do the same, and we now learn from Dr. B. Poulton, of Adelaide, the Secretary to the Executive Committee, that the Victorian Railway Commissioners have granted a similar concession; therefore, members of the Congress, on production of their member's ticket, will obtain a return ticket at a single fare over the railways in the three colonies.

Dr. Poulton also informs us that Dr. J. Foreman, Obstetric Physician at the Prince Alfred Hospital, Sydney, has been chosen as Chairman of the Section on Gynaecological Medicine and Surgery, and will, of course, deliver the initial lecture on Gynaecology, whilst Mr. T. N. Fitzgerald, F.R.C.S.I., Honorary Surgeon of the Melbourne Hospital, as Chairman of the Section on Surgery, will deliver the lecture on Surgery.

Members of the Congress who intend to read papers, will please bear in mind that the 30th June has been fixed as the final date for notice to the secretary.

NOBLE *v.* MARSDEN.

This case, tried at the District Court, Sydney, on May 18, was commenced with the object of recovering £200 damages from the defendant, a medical practitioner, for slander. It appears that the wife of the plaintiff consulted Dr. Marsden as a club patient, and he, having examined her, expressed his opinion as to the nature of her disease; this opinion, the plaintiff averred, cast doubt either upon the chastity of the wife, or on the moral conduct of the husband. The case was tried without a jury, his Honor, Judge Dowling, giving a verdict for the defendant with costs.

We sympathise with Dr. Marsden in this case, for the conscientious opinion of the medical attendant expressed to the patient or her husband cannot be a slander, even though that opinion may be erroneous. We would, however, point out to medical men that the expression of opinion as to the disease of a patient to any person who is not concerned, either by being the guardian or husband, or by being the officer of a society to which the nature of the disease is a matter of concern, would undoubtedly be a slander, in addition to being a gross breach of professional confidence.

MEDICAL EVIDENCE AT CORONERS' INQUESTS.

The late Attorney-General of New South Wales, Mr. Foster, Q.C., recently gave an opinion which led to the Minister for Justice directing Coroners that for the future, the practice which has hitherto existed of allowing the medical witnesses at inquests to write down their evidence, to be afterwards read over in their presence to the jury, should be discontinued. We think this a mistake, for the sight of a coroner's clerk struggling in agony with the numerous technical words used of necessity by medical men, is a pitiable one, and the evidence so taken down would probably, if referred to in after years be almost unintelligible from mis-spelling. In addition, much time will be lost, and the thread of the evidence so broken as to be capable of conveying but a faint idea of the meaning of the witness to the jury, as a rule composed of men not of the highest intelligence or acquirements.

THE QUEENSLAND MEDICAL SOCIETY.

We desire to call the attention of the other medical societies of Australasia to the excellent work that is being done by the recently resuscitated Medical Society of Queensland. At the meetings of all the societies, excellent and interesting papers are read by the members, but the matter is generally allowed to drop without much discussion. At the Queensland Society's meetings, things are different, the discussions are more lengthened and practical, and the members express their opinions freely, even though they may not be those generally accepted. The progress of practical medicine is so intimately connected with free discussion, that practice in Queensland undoubtedly receives material advancement by the aid of its Medical Society.

MR. L. BRUCK, of 35 Castlereagh-street, Sydney, has just received a supply of Dr. Oliver's Urinary Test Papers, such as albumen, indigo carmine sugar, and alkaline litmus acidity test papers; also, nickel metal pocket cases containing the whole of Dr. Oliver's Urinary Test Papers, including specific gravity bead and tubes. These new test papers are very sensitive, and in the hands of the busy practitioner they afford a rapid and reliable bedside test, and obviate the inconvenience of carrying caustic fluids, which are, under any circumstances, very unmanageable pocket companions.

LETTERS TO THE EDITOR.

AN AUSTRALIAN PRACTITIONER AT THE NEW YORK POLYCLINIC.

(To the Editor of the A.M.G.)

MY DEAR SIR,—When I left Sydney, I promised to write you from the Polyclinic here. I have been attending it for the last two months, and intend to remain here till the first of May. "The New York Polyclinic" is a School of Clinical Medicine and Surgery, to which only practitioners are admitted. The teachers are members of the medical profession of New York, who, in their personal connections with the city hospitals (of which there are about 26) and dispensaries, control a vast clinical material, and are all very clever men and high up in the profession. Our best surgeon is a German, from Berlin, his name is Gerster, and he is one of the cleverest surgeons I ever saw. There are about 260 practitioners attending, most of them taking a course of three months. For any man who would wish to make a specialty of any branch, this is the place for him to attend, as he can have every chance to devote his whole time to any one branch he likes. I am taking all the classes in the clinic, and do not devote more time to one than another, except Gynaecology and Orthopaedic Surgery. We are divided into several sections of a limited number, so that the members are brought into intimate personal contact with the patients, when the clinical features of each case may be minutely and leisurely studied and thoroughly understood. All the major operations in surgery are performed in the large hospitals every day, to which all of us are invited to attend for about three hours every afternoon. A large number of operations in minor surgery are performed every day in the operating room of the Polyclinic. I may mention, that for minor surgery, cocaine is used altogether; in fact, in the hospitals and private practice in New York, chloroform is never used; the Doctors all use ether, they would consider it a crime to use chloroform, except in some cases of children and in obstetrics. As far as our professors are concerned, we have some from Germany, France, Great Britain and America, and all good men. You see we have the teaching and opinions of the medical world, if I may be allowed to use the expression. In a very few years, I believe, the Polyclinic in New York will surpass Vienna and Berlin, and really I don't see why it should not be as good at all events, for I am quite sure the men and material are in New York, as well as in Berlin and Vienna. In Gynaecology we have such men as Emmet, Thomas, Keith, Wylie, Hunter, Mundé, Sims, junr., and several others; in surgery such men as Gerster, Wyeth, Szurs, Murco, Bull, &c.; diseases of the mind and nervous system, Profs. Starr and Gray, also Hammond and several others. I might go on and mention scores of men whose reputation is well known in the different branches of the medical profession, but it is not necessary to do so in a short letter like this. In my opinion, if the older countries don't look out, America will have the lead in medicine and surgery if they keep going on at the same pace as they have done in the last few years. Why, it is a shame for England, Scotland, and Ireland, that neither of them have such a thing as a Polyclinic or a Post-Graduate School, both of which New York can boast of. Indeed, the large number of physicians who have attended the Polyclinic this year, the majority of whom have been practitioners of considerable experience, is evidence that instruction,

entirely separate from that given to under-graduates, was a real need. The faculty of this school were the first in this country to arrange a thorough and complete system of clinical instruction for physicians, and they mean to leave nothing undone on their part to render the medical facilities of New York as renowned for clinical study as those of Paris, Berlin, or Vienna. These facilities now make it unnecessary for an American practitioner to visit European schools for the purpose of securing special and advanced instruction, for such he now can get at home.

Yours very truly,

M. MATHESON, M.D.,
(Late of Aramac, Queensland.)

New York Polyclinic, March 16, 1887.

PURULENT OPHTHALMIA IN NEWLY-BORN CHILDREN.

(To the Editor A. M. Gazette).

SIR,—I beg to be allowed to add a remark to Dr. Symons' interesting paper on "Purulent Ophthalmia in New-born Children," (*vide A. M. G.*, May 15).

There was lately a proposition before the Berlin Medical Society to adopt a prophylactic treatment in regard to ophthalmia neonatorum. The affair was referred to the Koenigl. Wissenschaftliche Deputation für das Medicinalwesen. The report of the latter is published in the *Vierteljahrsschr. fürgerichtl. Med.*, vol. XLIV, page 344, and states that the recommendation of Credé to apply directly after birth a few drops of a 2% lotion of nitrate of silver into the eyes, is doubtless effective, but the lotion irritates the conjunctiva, and thus may be the cause that a commencement of the ophth. blennh. may be overlooked. The prophylactic installation of a sublimate lotion (0·2%) is preferable because it irritates the mucous in a lesser degree.

The scientific deputation also expressed the opinion that a prophylactic treatment should not be made obligatory in the gynaecological clinics, and certainly no midwives should be compelled to adopt it.

Experiments in the Berlin University clinics (Department of Gynaecology) proves that two different kinds of ophthalmia neonatorum have to be considered. One is of a mild nature, its secretion is thin and fluid-like, and vanishes mostly in a few days without any stringent measures. The other is of an inflammatory and purulent nature. The microscopical examination of the secretion in 1,700 cases proves that in the secretion of the former no micro-organisms of any kind are to be found, while in the latter *diplococci* were always detected. These *diplococci* are identical with those found in cases of gonorrhœa. It may be therefore considered to be proved that children only whose mothers are suffering from blennorrhœa, become afflicted with genuine purulent ophthalmia, and also for this reason a general prophylactic measurement in regard to ophthalmia neonatorum is not recommendable. Cleanliness to the eyes of new-born children is a matter of course.

With the above I have given solely the opinion of the scientific corporation mentioned.

Believe me,

Yours faithfully,

B. SCHWARZBACH.

Macquarie-street, Sydney, May 21, 1887.

FRIENDLY SOCIETIES.

(To the Editor of the A. M. Gazette.)

SIR.—I read with great interest the excellent articles on Friendly Societies in the last three numbers of the *A. M. Gazette*, but I fear that without unity there will be no relief. We tried it here; we all agreed to let one doctor have the lodges, provided he charged the old fee of £1 1s. per single member, £1 5s. for married, and £2 2s. for confinements. None of us sending in tenders, the local Societies imported a new doctor as a counter move to get medical attendance cheaper; this one left them in disgust after two years. We tried the same remedy, guaranteeing the last medical attendant that we would not tender if he alone would again take them at the old rates, which had been in force from 1862 to 1879; but again the clubs imported a new medical man, a Dr. Edgeclow, and their former doctor swelled the already long list of the private practitioners. If Dr. Edgeclow should not suit, I believe they will import another doctor, and Dr. Edgeclow will compete with us in private practice, as his predecessor did. Even threatening to refuse to consult with a lodge doctor did not help us, as some one or another dropped out of the agreement. "No unity, no help." What could we not do if we stuck together like the lawyers!

Yours, &c.,

SUBSCRIBER.

Rockhampton, Queensland, May, 1887.

DRUMINE.

(To the Editor Australasian Medical Gazette.)

IN the *Therapeutic Gazette* (Pa., U.S.A., April 15, 1887, pp. 246 and 7) is a critique on drumine with a reference to a prophecy in an old number, to the following effect. "As we at that time stated, we did not regard Dr. Reid's experiments as sufficiently accurate to prove the truth of his statements, and unfortunately some recent experiments with the same agent by Prof. Alexander Ogston (*British Medical Journal*, February 26, 1887) appear to confirm our views as to the unreliability of Dr. Reid's statements." I am not much of a prophet, but I shall give the writer of the above less than two years to recant. Unfortunately, I sent four specimens home to Messrs. Savory and Moore, the late Prof. Dyce Davidson, Dr. P. Blackie Smith, and Prof. A. Ogston. Prof. Dyce Davidson received a dry specimen, the others wet. Of the others, Dr. P. B. Smith and Messrs. Savory and Moore wrote to say their specimens were decomposed. Prof. A. Ogston informed my brother that he intended to write in order to prevent the public from being deluded, as drumine had been noised abroad too much, and only at the suggestion of my brother did he add the possibility of decomposition, notwithstanding my note to that effect in the original communication to the *Australasian Medical Gazette* in October, 1886. I will say nothing of Prof. Ogston's method; but I will add that his experiments in the main bear out my own experiences with decomposed alkaloid. With the experience on a variety of persons of varied character to back me, I have not the slightest doubt but that the pure hydrochlorate of drumine in aqueous solution will answer the requirements from a physiological and clinical standpoint, as described by me.

JOHN REID, M.A., M.D., ET C.M.

143 Collins Street E., Melbourne,
June 2, 1887.

REVIEW.

The Myology of the Limbs of Dasyurus Vicerinus.

BY ALEXR. MACCORMICK, M.D., EDIN., Demonstrator of Anatomy, University of Sydney, N.S.W.

(Reprinted from the *Journal of Anat. Physiol.*, vol. xxi.)

THAT this paper is a valuable contribution to the comparative anatomy of the marsupials is evidenced by the fact of the University of Edinburgh having awarded a gold medal to the author, on his presenting it as his thesis for graduation as Doctor of Medicine.

It is gratifying to note such a paper as the result of original work done in the yet embryonic Sydney Medical School. We may hope that in the future much, if not most of the comparative study of Australian mammals, may be carried on by scientific effort in this part of the world. The special value of Dr. MacCormick's paper lies in its being an attempt at the accurate systematic description of a part of the muscular arrangements of *Dasyurus*—an animal which had not hitherto received such special attention—with a view to the recognition of the homologies of these structures. At the same time the descriptions are, to some extent, collated with similar researches upon other marsupials, recorded by various observers, and thus the new facts are assigned their place in the body of knowledge relating to this order. Such a relation of the facts constitutes no small element in the value of the whole. The paper is mainly, or entirely, descriptive; there is no attempt at scientific generalisation, but for this feature the author is deserving of our approbation, for, although hypothesis and generalisation are the crown of scientific work, there can be no more disastrous result in biological, or indeed in any natural science, than that which issues from attempts at hasty induction, or raw generalisation, from insufficient or ill-considered data, or from the launching of hypotheses which have not undergone the most stringent and testing comparison with a large body of ascertained and admitted fact.

The mode of statement is, as might perhaps be expected, essentially that of human descriptive anatomy, with such modifications as are rendered necessary by the difference between the respective points of view of zootomy and anthropotomy. These modifications have apparently been reduced to a minimum, and we detect in a few instances a

certain lapse from absolute accuracy of statement, due to the intrusion of the anthropotomical standpoint in the use of such terms as "anterior," "inferior," &c. Such errors are, however, but trifling slips, and on the whole the descriptions are thoroughly accurate and admirably worded.

The worth of the paper would certainly have been increased had it contained notes upon the innervation of the muscles, but this might very appropriately form the subject of a subsequent essay.

In any case we welcome every such addition to the mass of ascertained and recorded morphological fact, and not the less heartily since it is in this instance a record of the careful observations of an able worker in the University of Sydney.

The lithographic drawings are admirable, and we think it is to be regretted that some of the illustrations referred to in the text have not been reproduced.

THE INSANE POPULATION OF NEW ZEALAND IN 1886.

DR. DUNCAN MACGREGOR, Inspector of Asylums in New Zealand, has forwarded us his report for the year 1886, from which we learn that the number of registered insane persons on the 31st December, 1886, was 1,618, viz.:—1,009 males, and 604 females, or 1 lunatic for every 370 of the population.

On the 1st January, 1886, the number of registered lunatics was 1,524 : males 981, and females 543. Those admitted during the year for the first time numbered 302 : males 170, females 132. The re-admissions amounted to 70 : males 37, and females 33.

159 patients were discharged recovered, and 48 were discharged not recovered ; the proportion of recoveries to admissions for the year was 42·74 ; the deaths in 1886 were 57 males, and 19 females, in all 76 (against 95 in 1885), or a percentage of 1·37 on the total number under care, and 2·04 on the admissions.

As regards the ages of the admissions, 9 were between 5 and 15 years of age, 29 between 15 and 20 years, 88 between 20 and 30 years, 90 between 30 and 40 years, 76 between 40 and 50 years, 47 between 50 and 60 years, 20 between 60 and 70 years, and 4 between 70 and 90 years. 301 of the admissions were single, 134 married, and 34 widowed. Of the 1,613 insane persons under care on December 31st last, there were 562 English, 475 Irish, 265 Scotch, 111 New Zealanders, 37 Germans, 21 Australians, 21 Maoris, 21 Chinese, 15 Swedes, 14 Danish, 13 French, &c. The principal causes of insanity were :—drink 37, hereditary 35, congenital 16, masturbation 12, adverse circumstances 10, climacteric 10, old age 10, &c. The total average cost per patient was £27 8s. 9d., or less repayments, £24 0s. 5d. The total expenditure during the year amounted to £46,644 5s. 7d., and the repayments to £5,407 14s. 2d.

THE MONTH.

NEW SOUTH WALES.

AT the annual commemoration of the University of Sydney, on May 14, the degree of M.D. (*a.s.g.*) was conferred on Dr. W. Chisholm, of Sydney ; the degree of M.B. (*a.s.g.*) on Dr. H. A. Ellis, of Double Bay ; and the degrees of M.B. *et* Ch. M. (*a.s.g.*) on Dr. W. Andrews, of Melbourne.

THE report of the medical adviser to the Government upon the vaccinations performed during 1886, has come to hand. It states that 1,753 public vaccinations were performed during the year, as against 2,193 in 1885, and 7,055 in 1884. This return is the lowest for the past 26 years, excepting 1883, when only 882 public vaccinations were recorded. During this period there were 601,965 births, but only 235,429 of the children were vaccinated by the public officers. From this it is evident that a very large proportion of the population is unprotected from the attacks of smallpox—a circumstance which Dr. MacLaurin regards with alarm, in view of the great danger of this loathsome disease being introduced by the frequent and rapid communication which now exists between Australia and other parts of the world.

THE report on the Coast Hospital, Little Bay, for the year 1886, just issued, shows that the total number of patients admitted during the year was 1,278 ; 120, or 9·38 per cent. died, and the average daily number in the institute was 146 $\frac{1}{2}$. The average stay in the hospital was 41·6 days, and the daily cost per head was 3s. 2d. Deducting the expense of transport, the cost per head was only 2s. 10d. The prolonged average stay in the hospital was due to the admission of a large number of cases of chronic illness, which had hitherto been chiefly accommodated in the hospital wards of the various benevolent asylums. Most of the deaths (63) during the year were from zymotic diseases, and these all of the miasmatic order.

AT the Metropolitan Quarter Sessions, on May 27, before District Court Judge Wilkinson, Amy Thomas, John Smith, and Richard Sidney Marjoram were arraigned on a charge that, on March 28, at Sydney, they conspired together to falsely charge and accuse Dr. H. G. A. Wright, of Sydney, of having criminally assaulted the said Amy Thomas. The jury, after a short deliberation, found the prisoners guilty. Smith and Marjoram were sentenced to 14 years, and Amy Thomas to five years penal servitude.

A PATIENT in the Newcastle Hospital died on May 11 whilst chloroform was administered, preparatory to an operation. An inquest was held, and the verdict returned "that deceased died whilst under chloroform, and that all due care was exercised by the doctors."

THE Kiama Cottage Hospital was formally opened on May 21.

A MARBLE monument, in memory of the late Dr. Lacey, of Kiama, was unveiled in the cemetery there on May 11.

TYPHOID fever has been unusually prevalent at Kiama, where upwards of 60 cases occurred last month.

DIPHTHERITIC croup of a malignant type, is prevalent in the Gundagai district, about ten deaths, including several children, having occurred during the past month.

A movement is on foot at Newcastle, headed by Mrs. J. C. Ellis, to initiate a jubilee fund to establish a

cottage home for incurables in the district, which is much wanted.

DR. C. L. GABRIEL, late of Kempsey, has commenced practice at Gundagai, on the Murrumbidgee River, 289 miles S. of Sydney.

FRANCIS DORRINGTON NIBLETT, M.R.C.S. Eng., 1858, L.R.C.P. Edin., 1870, died at his residence, Alexandra-street, Hunter's Hill, near Sydney, on May 24, aged 60 years.

We regret to have to announce the death of Mr. Thomas Richard Aloysius Harney, M.R.C.S. Eng., & L.S.A. Lond., 1886, who died at his residence "Roseville," Park road, Burwood, a suburb of Sydney, on June 1. The deceased gentleman was a native of Sandhurst (Vic.); he completed his medical studies in England, and returned to Australia about ten months ago, when he commenced practice at Burwood.

DR. C. E. ROWLING, Visiting Surgeon to the Government Institutions at Parramatta, has been called upon to show cause why he should not be dismissed from the public service for his actions in connection with the Government Asylums.

DR. S. A. DOWE, of Gunnedah, has succeeded to the practice of Dr. Tennant, of Parramatta; Dr. Dowe has taken up his residence at Granville, formerly called Parramatta Junction.

DR. EDWARD DRUMMOND, formerly House Surgeon at St. Vincent's Hospital, has commenced practice at Croydon, a suburb of Sydney.

DR. W. R. HAWKINS has been appointed member of the Licensing Court for the district of Brewarrina.

DR. T. R. HORTON, of St. Peters (Sydney), has succeeded to the practice of Dr. J. Diamond, at Mudgee.

DR. G. NAGEL, from Berlin, a specialist for diseases of the eye, has commenced practice at 32 College-street, Hyde Park, Sydney.

NEW ZEALAND.

We regret to have to announce the death of Dr. Henry Sorley, M.D. et Ch.M. Glas., 1832, who died on the 2nd February last, at his residence, Victoria Avenue, Wanganui, from gradual dissolution; about eighteen months previously he fell downstairs and sustained concussion of the brain, and since then he was never himself, but gradually failed until the end came. There were not many men in the colony who had a longer term of professional activity than the deceased gentleman, who took his degrees fifty-five years ago. In 1862, he came to Victoria, and practised for many years at Bacchus Marsh, which place he left for New Zealand about twelve years ago; he then practised at Wanganui till five years ago, when he retired from active work, and handed his practice over to his son, Dr. John Sorley, who is still practising at Wanganui.

DR. A. F. WRIGHT, a new arrival, has commenced practice at Te Aroha, in a gold-mining district, 60 miles S.E. of Auckland.

QUEENSLAND.

DR. W. F. THURSTON, Government Medical Officer at Rockhampton, has been granted leave of absence for eight months; Dr. Voss, late of Bowen, will carry on his practice during the said period.

DIPHTHERIA has been very prevalent last month in Brisbane and suburbs, many deaths of children resulting therefrom.

SOUTH AUSTRALIA.

DR. C. W. HAMILTON, of Laura, and Dr. S. Horneck, of Morphett Vale have been appointed Justices of the Peace.

TASMANIA.

DR. W. COTTERELL, late of Ballarat (Vic.), and formerly of New Zealand, has commenced practice at Launceston.

DR. W. G. WEAVER, a native of the colony, has commenced practice at Hobart.

CERTAIN charges against the authorities of the Hobart General Hospital, promulgated by Dr. A. Birmingham Crowther, utterly broke down when investigated by the board of management.

VICTORIA.

AT the meeting of the Council of the Melbourne University, held on May 16, a rather impudent letter was received from Professor Allen, accepting the *douceur* of £250 for the transference of the pathological specimens, but reserving to himself the right of ceasing to act as demonstrator of morbid anatomy without infringing his tenure as professor of anatomy and pathology. On the motion of Mr. Justice Webb, the following resolution was agreed to:—"That Professor Allen be informed that the council, having already determined that the duties of demonstrator of morbid anatomy are included in those of professor of descriptive and surgical anatomy and pathology, cannot recognise a right being reserved to any professor to cease at any time, without the sanction of the council, to discharge any part of the duties of his chair."

THE Railway Commissioners have appointed Drs. McCrea, O'Hara, W. B. Rankin and C. S. Ryan to watch the condition of the sufferers by the dreadful railway disaster near the Windsor station on May 11, to report on the extent of their injuries, and to protect the interests of the public in respect to probable claims for damages.

THE typhoid camp at the Alfred Hospital, opened on February 18, was finally closed on May 26. The patients remaining under treatment in the tents were, owing to the coldness of the night air, transferred to the general wards. The total number of typhoid fever patients admitted into the tents was 69, viz., 57 males and 12 females; 8 had died, 49 were discharged, and 12 were still remaining under treatment. The percentage of deaths was 11.5.

The next election of Honorary Medical Officers of the Melbourne Hospital will take place on August 18.

IN consequence of an outbreak of typhoid fever, the Geelong Grammar School has been closed; six of the boarders are prostrated with fever, and three domestics are also suffering from the same complaint. It is asserted that the fever was introduced by means of milk supplied to the institution.

DR. A. A. FLETCHER has been appointed Public Vaccinator at Lygon-street, Carlton, and at the Manchester Unity Hall, Swanston-street, Melbourne, acting in conjunction with Edward Fletcher, Esq., M.R.C.S., the present Public Vaccinator at those places.

DR. T. M. GIRDLESTONE, of Melbourne, has removed from 101 Spring-street to 164 Collins-street east.

DR. A. HAYNES has commenced practice at Benalla, the centre of an agricultural and pastoral district, 122 miles N.E. of Melbourne.

DR. E. M. INGLIS has commenced practice at Princess-street, Kew, a suburb of Melbourne.

DR. R. McCALL, of Euroa, has removed to Chiltern, in an agricultural and mining district, 169 miles N.E. of Melbourne.

DR. W. MOIR, late of Bombala (N.S.W.), has commenced practice at Warracknabeal, in an agricultural and pastoral district, 262 miles N.W. of Melbourne.

DR. J. F. MOLYNEUX has settled at Williamstown.

DR. T. B. RYAN has resigned his office of Junior Deputy Medical Superintendent of Hospitals for the Insane in Victoria.

DR. JOHN SUTHERLAND has resigned his position as Resident Surgeon of the Alfred Hospital.

DR. ED. HARKNESS, of Maryborough, has removed to Surrey Hills, near Melbourne.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Ogden, William Henry, L.R.C.S. Irel. 1878; L.K.Q.C.P. Irel., 1879.
Taylor, George Henry, L.R.C.P. Edin., 1882; L.R.C.S. Edin., 1882.
Nagel, Günther, M.D. Berlin, 1881; Staat's-Examen. Certif. Berlin 1882.
Nichol, Henry, L.R.C.P. Edin., 1880; M.R.C.S. Eng., 1880.
Wilson, James Thomas, M.B. et M.S. Edin., 1883.

NEW ZEALAND.

Bancroft, Thomas Lane, M.B. et Ch. M. Edin., 1883.
Pitt-Henry, George William, M.R.C.S. Eng. & L.S.A. Lond., 1886.
Lindsay, Peter Alexander, M.B. et Ch. M. Edin.
Wright, Alfred Figg, L.R.C.P. Edin., L.F.P.S. Glas., L.Mid. Edin. and Glas.

SOUTH AUSTRALIA.

Lawrence, Alexander, M.B.
Purves, Charles William, L.R.C.P. et R.C.S. Edin., 1883.
Stow, Charles Lethbridge, M.R.C.S.E., 1882; L.R.C.P. Edin.; 1883.

TASMANIA.

Fitzgerald, Joseph, L.R.C.S.I., 1871; L.K.Q.C.P. Irel., 1873.

VICTORIA.

Mullally, William Thomas, M.D. et Ch.M. Q. Univ. Irel., 1880; L.Mid. K.Q.C.P. Irel., 1886.
Hayes, James Bennett, L. et L. Mid. R.C.P. et R.O.S. Edin., 1880.
Haynes, Abraham, L. et L.Mid. R.C.S. Edin., 1886.
Chapman, John Taylor, L. et L.Mid. R.C.P. et R.C.S. Edin., 1886; L.F.P.S. Glas. 1886.
Magill, Martin, M.B. et Ch.B. Melb., 1887.
McAdam, Robert Louis, M.B., Ch.B., M.D. Dubl., 1886.
Russell, Charles Donald, M.B. et Ch.B. Melb. 1887.
Deravin, Hugh Alexander, M.B. et Ch.B. Melb., 1887.
Llewellyn, James Davies, L.R.C.P. Lond., 1886; M.R.C.S. Eng., 1882; L.S.A. Lond., 1882.
Hodgson, Thomas, M.B. et Ch.B. Melb., 1887.
Moir, William, M.B. et Ch.M. Aberd., 1883.
Molyneux, John Francis, M.R.C.S. Eng., 1883; L. et L.Mid. R.C.P. Edin., 1883.

Additional qualifications registered:—

Williams, Ezra H., M.D. et Ch.M. Univ. of Trin. Coll., Toronto, Canada, 1884; Rosenblum, Edward E., Ch.B. Melb., 1887; Thomson, James S., Ch.B. Melb., 1887; Boyd, William R., Ch.B. Melb., 1887; Flett, William S., M.D. Edin., 1886, M.D. Melb., 1887 (*a.s.g.*); Connor, Samuel, M.O. R. Univ. Irel., 1885; Barrett, James W., M.D., Melb., 1887.

MEDICAL APPOINTMENTS.

Deravin, Hugh Alexander, M.B. et Ch.B. Melb., appointed Assistant Resident Medical Officer at the Bendigo Hospital, Sandhurst, Vic., vice Dr. J. Boyd, jun., resigned.

Dunlop, James Dunlop, M.B. et Ch.M. Edin., L.R.C.P. et R.C.S. Edin. to be Public Vaccinator at Glenelg, S.A.

Hakins, George Reginald, M.D. et Ch.D. Brux., L.R.C.P. et R.C.S. Edin., of Echuca, Vic., to be Government Medical Officer and Vaccinator for the district of Moama, N.S.W.

Lawrence, Alexander, M.B., to be a Public Vaccinator at Adelaide, S.A.

McCall, Robert, L.R.C.P. et R.C.S. Edin., to be Public Vaccinator Chiltern, Vic., vice Dr. F. Haley, resigned.

Moore, Thomas Dawson, L.R.C.S. Irel., to be Health Officer for the borough of Queenscliff, Vic., vice Dr. Walter Scott, resigned.

Parkinson, Richard Colville, M.R.C.S.E., L.K.Q.C.P. Irel., to be an additional Public Vaccinator for the district of Auckland, N.Z.

Purves, Charles Williams, L.R.C.P. et R.C.S. Edin., to be a Public Vaccinator for South Australia.

Stoker, Henry, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Public Vaccinator at Wycheproof, Vic., vice Dr. C. H. Degner, resigned.

Tennant, Thomas Hately, L.F.P.S. Glas., to be Honorary Surgeon of the Upper Clarence Reserve Corps of Volunteer Light Horse, N.S.W.

Terrey, Caleb, M.B. et Ch.M. Edin., elected Visiting Medical Officer to the Kiama Hospital, N.S.W.

PUBLICATIONS RECEIVED.

Medical Education and Medical Colleges in the United States and Canada. Issued by the Illinois State Board of Health, Springfield, Ill.: H. W. Rokker, 1886.

Remarks on Hepatic Phlebotomy; and Puncturing the Liver's Capsule, as Curative Procedures in Hepatic Disease. By George Harley, M.D., F.R.S.

Eighth Annual Report of the State Board of Health of Illinois, with an Appendix. Springfield, Ill.: H. W. Rokker, 1886.

Address in State Medicine. By John H. Rauch, M.D. Chicago, 1886.

Transactions of the American Dermatological Society, at the tenth annual meeting held at Greenwich, Conn., in August, 1886. Boston, 1886.

Ueber Wirkung, therapeutischen Werth und Gebrauch des neuen Karlsbader Quellsalzes, nebst dessen Beziehung zum Karlsbader Thermalwasser. By Dr. W. Jaworski, Wien, 1886.

The Action and Uses of Digitalis and its Substitutes; with special reference to Strophantus. By Thos. R. Fraser, M.D., F.R.S., F.R.C.P.H. London: Burroughs, Wellcome & Co., 1886.

Burroughs' Medical Diary for the year 1887, especially providing for all matters of interest to the General Practitioner, including space for the entry of Daily Visits, Accouchements, Vaccinations, &c. London and Melbourne: Burroughs, Wellcome & Co.

First and Second Special Reports upon the Improvement in the Scale of Diet in the Imperial Japanese Navy. Issued by the Sanitary Bureau of the Navy Department, Tokyo, Japan.

Treatment of Disease in Children, including the Outlines of Diagnosis and the Chief Pathological Differences between Children and Adults. By Angel Money, M.D., M.R.C.P. London: H. K. Lewis (1887).

On Fevers: Their History, Etiology, Diagnosis, Prognosis and Treatment. By Alexander Collie, M.D. With coloured plates. London: H. K. Lewis (1887).

REPORTED MORTALITY FOR THE MONTH OF APRIL, 1887.

CITIES AND DISTRICTS.	POPULATION.	BIRTHS REGISTERED.	DEATHS REGISTERED.	DEATHS UNDER FIVE YEARS.	MEASLES.	NUMBER OF DEATHS FROM						
						SCARLET FEVER.	GROUP AND DIPHTHERIA.	WOOING COUGH.	TYPHOID FEVER.	DYSENTERY AND DIARRHOEA.	PHLEBITIS.	HEART DISEASE.
N. S. WALES.												
Sydney	135,000	316	147	66	...	...	3	8	2	4	6	13
Suburbs	200,000	769	327	172	...	3	8	4	13	30	28	22
NEW ZEALAND.												
Auckland	35,965	54	38	22	...	1	1	2	...	5	5	1
Christchurch	15,684	38	18	9	...	3	3	1	1	1	3	1
Dunedin	24,233	57	17	3	1	...	...	...	...	1	4	...
Wellington	26,956	76	87	19	...	1	...	...	4	2	2	1
QUEENSLAND.												
Brisbane	32,571	112	86	23	{	13	2	5	15	9	4	2
Suburbs	41,082	200	83	44	...	...	...	...	8	3	7	5
SOUTH AUSTRALIA.												
Adelaide	307,300	902	899	178	...	9	3	29	38	25	25	9
.....	42,904	101	81	25	...	2	3	...	8	7	5	2
TASMANIA.												
Hobart	30,972	74	37	18	...	1	3	16	2	5	6	4
Launceston	19,333	58	31	7	...	1	...	6	1	4	2	1
Hospitals, Asylums, Gaols, &c. .	1,341	...	43	...	...	...	...	...	...	...	...	...
Country Districts.	88,284	213	67	...	...	5	...	1	4	...	...	...
VICTORIA.												
Melbourne	69,774	163	103	1	...	10	4	57	48	79	40	16
Suburbs	275,606	1,063	696	271	...	...	...	...	...	...	...	29

METEOROLOGICAL OBSERVATIONS FOR APRIL, 1887.

STATIONS.	THERMOMETER.					MEAN HEIGHT OF BAROMETER.	RAIN.		MEAN HUMIDITY.	PREVAILING WIND.
	MAXIMUM SUN.	MAXIMUM SHADE.	MEAN SHADE.	MINIMUM SHADE.	DEPTH.		INCHES.	DAYS.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	...	...	...	...	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	181	73	63·1	48	...	...	1·980	12	80	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 16" E.	148·7	84·1	67·2	55·1	30·107	3·341	28	85	...	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	187	78·8	55	37	...	1·713	9	70	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E. ....	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	80	56	39	30·131	.77	7	79	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	77	57·3	33	30·196	5·89	7	77	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	90·6	59·5	41·3	30·125	4·84	13	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	88·9	65·2	61·6	30·212	7·12	23	79	...	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	128	71	57·7	41	...	2·022	11	81	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

SUPRA-PUBIC CYSTOTOMY FOR REMOVAL OF FOREIGN BODY WITH CALCULUS ATTACHED.

By G. GORE GILLON, M.B. & C.H.M., GLAS.,
HON. VISITING SURGEON WELLINGTON HOS-
PITAL, NEW ZEALAND.

[Illustrated.]

SYMPTOMS.—B. B., aged 43, single, a carpenter, admitted March 26, 1887, complaining of pain in the hypogastric region and also pain when passing water, the water frequently "stopping" and causing great uneasiness. Blood has passed occasionally and badly-smelling urine. His urine contained a large quantity of pus and some triple phosphate crystals.

HISTORY.—He states that he had enjoyed fairly good health until 4 years ago, when he was in the Riverina district in New South Wales. He was employed on the railway works there, and the weather was very hot and the drinking water both scarce and of bad quality. In May, 1883, he noticed a small stone pass from his urethra—and again in August, 1883, he passed another small stone. In April, 1884, he felt another stone lodged in "the pipe," and to relieve himself of the agonising pain he inserted a bone pen-holder (about 5 inches long) into the urethra, and tried to push the stone back by this means into the bladder. He succeeded in doing this, but at the same time the pen-holder slipped up into his bladder.

For some days after he suffered great pain whenever he moved about, but never consulted any doctor about it. He continued at his occupation until July, 1884, when he went to England. While there he consulted Dr. Campbell, of Gloucester, who wanted to operate on him. He would not agree to an operation, but sailed for New Zealand, where he has been ever since October, 1884, attending to his ordinary work as a carpenter.

EXAMINATION.—On examination I found that the sound struck a hard substance apparently just at the neck of the bladder. By rectal examination nothing more was made out than that there was a hard substance of ill-defined shape in the bladder. On examining externally I found a hard lump in the left iliac region, midway between the crest of the ilium and a point 4 inches below the umbilicus in the middle line of the abdomen. This lump

was fixed, and appeared to be very close to the abdominal wall. On tapping with the end of the sound in the bladder against the foreign body, a thrill was distinctly felt by the other hand placed on the hard lump in the abdomen. This made it clear that there was continuity of structure between these two points, and it seemed very probable that one end of the pen-holder was high up in the iliac region in a pouch of the bladder, and the other end at the "neck" with the calculus most likely attached.

After a consultation with the Hon. Dr. Grace (Consulting Surgeon), and Dr. Hassell (Resident Surgeon), I decided to perform Supra-pubic Cystotomy for the following reasons:—

1. That probably the calculus had grown considerably, and was most likely attached to the foreign body, thereby making a considerable bulk.
2. The foreign body being absolutely rigid and probably encrusted, it would be useless to try and extract it "per urethram."
3. That by the "high" operation I could get a better knowledge of the existing state of things in the upper part of the bladder, and see how far and in what way the succulation of the bladder had occurred.

OPERATION.—Accordingly on the 2nd April, 1887, in the presence of the Hon. Dr. Grace, Drs. Kemp, France, McIver, and Hassell, I performed the operation described by Sir Henry Thompson in 1886.

The patient's pubes having been shaved, he was placed on a high operating table and fully anaesthetised.

I then inserted an empty Barnes' Bag (capable of holding 10oz. of fluid), well oiled, into the rectum well above the sphincter, and slowly injected 10oz. warm water, and turned off the stop-cock. The bladder was then injected with 8oz. warm Thompson's fluid diluted 1—6, and a piece of drainage-tubing tied round the penis. By this means the outline of the bladder was clearly delimited by percussion. Owing to the distorted condition of the bladder, it inclined when distended well over to the left side; in fact, its right border only just reached the middle line of the abdomen. This somewhat complicated matters, as in all the cases I have seen reported the bladder occupied its normal position. I now made an incision down on the linea alba about $4\frac{1}{2}$ inches long, reaching from 4 inches below the umbilicus down to the pubes. Finding that the whole bulk of the bladder was on the left side, I cut through the fibres of the rectus muscle about half-an-inch

to the left of the linea alba, and then with great caution proceeded to work my way through the loose fat and veins lying behind the pubes. I did this with the handle of the scalpel mainly, and a hook and probe, gradually edging towards the left side and upwards. Drs. Grace and Kemp held the muscular parts asunder with retractors, and I soon came down on the surface of the bladder, which was of a dull purplish hue and striated. I then made an incision into the bladder, and some "fluid" at once escaped. Inserting my index finger into the viscus, I found a large calculus situated at the "neck," and arising out of it I felt the pen-holder with the upper end fixed in a pouch at the left side above. The walls of the bladder were greatly thickened and fasciculated, and I found that it would be impossible to remove the foreign body in its entirety, owing to the rapid contraction of the bladder—and then I was afraid to use the least force for fear of pushing the upper end of the pen-holder through the bladder-wall into the peritoneal cavity. Having previously tested the ability of a pair of bone-forceps to break another bone pen-holder which I had brought with me, I introduced the bone-forceps into the bladder and broke the pen-holder across, just above its exit from the upper end of the calculus. I then easily extracted first the lower part with the stone attached, and then the upper end of the pen-holder with my two index fingers, using a gentle swaying motion with the last part. The calculus measured $2\frac{1}{2}$ inches, and the pen-holder $5\frac{1}{2}$ inches. The weight of the calculus and holder was $2\frac{1}{4}$ oz. The calculus was composed of uric acid and triple phosphates. The bladder was then well washed out with Thompson's fluid and explored thoroughly, but nothing else was found in it.

One end of a drainage-tube was placed in the bladder, five carbolised catgut sutures put deeply in the muscular tissues, and five silver wire sutures used to unite the skin, &c., at the upper and lower ends of the wound. The drainage-tube was kept in its position in the lower half of the wound by means of sticking-plaster. The wound was dressed with iodoform, and over that carbolised oil lint, and G.P. tissue. Over all a pad of cotton wool and a scultetus bandage was fixed.

TREATMENT.—The patient was then removed to his ward and turned on the right side, and a morphine suppository $\frac{1}{2}$ gr. placed in the rectum. Ordered a grain of opium in pill every 4 hours.

3rd April.—Patient passed a good night—urine running freely through the tube into a vessel on the floor, the amount for the first 24 hours being 40oz. Temp. 99.4 last night, 98.6 this morning. Abdomen well greased with eucalyptol and vaseline.

4th April.—Patient turned on either side every 8 hours. 45ozs. urine passed. Bladder washed out through the tube twice a day with warm Liq. Hyd. Perchlor. (1-5000). Opium pills stopped last night. Temp. last night 99.6—this morning 98.6.

5th April.—Takes fluid nourishment well—feels quite easy—and sleeps fairly well. Temp. normal night and morning. 50ozs. urine passed. Wound looks well. Tube syringed out with Thompson's fluid twice a day.

6th April.—As bowels were confined, given an enema. Temp. from this onwards quite normal. Wound to be dressed 3 times a day with iodoform and carbolised oil.

11th April.—Upper part of wound healed. The silver sutures removed. Lower part still gaping, but healthy looking. Ordered Fairchild's peptonising powders for his milk, as he suffered from indigestion. Some urine passed "per urethram" to-day after drainage-tube was removed. The urine still contains a lot of pus.

16th April.—Urine to-day escaped through abdominal opening. This was caused by severe straining due to vomiting after a dose of castor-oil.

17th April.—Urine comes both ways to-day. Wound granulating up from the bottom.

18th April.—Temp. 99. in the morning. Bladder to be washed out "per urethram" with a large soft catheter and warm Thompson's fluid twice a day. This was followed by a copious discharge of pus and phosphates. Ordered benzoate of ammonia.

20th April.—Temp. 99. at night for last 3 nights. Urine contains lots of pus. Ordered citrate of iron and ammonia.

23rd April.—Temp. 100.6 this morning from straining at stool, due to a costive motion. Constipation probably due to over-distension of rectum by use of Barnes' Bag and subsequent want of power in lower bowel (?). The straining this morning forced about an ounce of urine through the old wound in the abdomen. Glycerine added to iron mixture. Also ordered cascara sagrada in 60 minim doses daily.

25th April.—To have an enema every second day. All medicines stopped. Urine much clearer. Temp. quite normal. Urine ceased to come through abdomen from this date. Wound healing well. Ordered full diet.

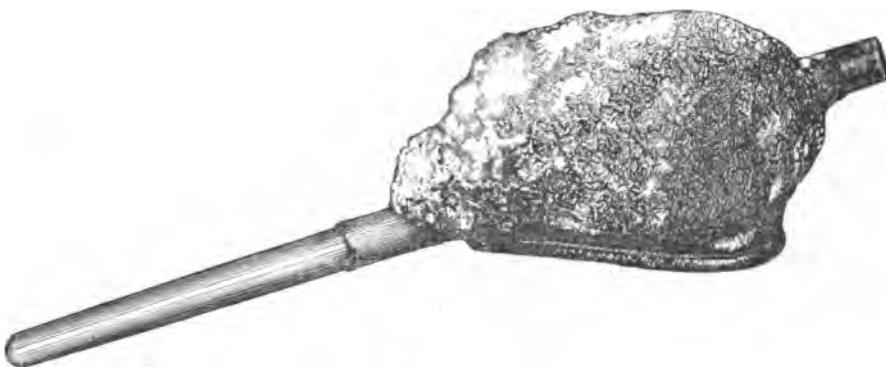
The patient progressed well from the 28th April. Temp. normal. Ate his food well and slept well. The temp. however rose on the 9th May to 101.6, and remained over the normal till 12th May, since which time it has been quite natural. This last rise was due, I think, to a little localised inflammation round the pouch in the bladder wall, as there is still to be felt in the

left iliac region, a hard lump. The wound had been improving daily, and was quite healed on the 17th May, when the patient got up and was able to move about the ward.

RESULT.—The injections were stopped on the

14th May, as the urine was much clearer, and he was able to hold his water for 6 or 8 hours. Discharged cured.

Here is an illustration of stone and pen-holder, showing where I broke the latter off—



COCAINE, AND ITS EFFECT ON THE EXTERNAL MUSCLES OF THE EYEBALL.

By GUIDO THON, M.D., ROCKHAMPTON,
QUEENSLAND.

LATELY some investigations have been published which tend to show that cocaine has some other effects on the eye besides producing anaesthesia of the conjunctiva, etc. It has been maintained that it causes a diminution of the tension and of the pressure of the external muscles of the eyeball. I have lately met with a case which seems to prove that these assertions are indeed true. On the 18th May Dr. C. kindly sent Mrs. B. to me with the request to examine the right eye of her infant, three months old. I could ascertain nothing certain about the beginning, but it was clear enough that the child had passed through a severe inflammation of the eye, not, however, dating from its birth. It was a weak, sickly-looking infant, born, as the mother said, before its time, covered from head to foot with an eczema squamosum, which, however, retained its vesicular character on the hands and on various parts of the face. On the hands were open, small sores, caused by rubbing, here and there covered with scabs, and especially on the outer canthus of the affected eye a patch of the size of a six-penny piece seemed to give great trouble. The mother related that the child continually tried to scratch it. The eruption had spread to the conjunctiva to some extent, and it bled easily on trying to open the lids. A thick crusta lactea covered the head. The baby was reared upon Nestle's Food and condensed milk, the mother having no milk.

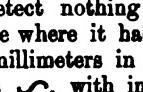
There was no intertrigo, nor any signs of specific disease.

On opening the lids the conjunctiva was not in any way inflamed, except that just parallel with the edge of the lid, and about one mm. below it, a red streak ran from one canthus to the other as well in the lower as upper lid, otherwise the palpebral conjunctiva was normal, perhaps somewhat pale.

The cornea was slightly opaque throughout, but in the middle of it, radiating to all sides, was a dense white and completely opaque spot, like a leucoma, in form much like one of those figures shown by a perimeter sometimes, an irregular polygon with the points (apices) of the angles extended, leaving a more or less semi-transparent irregular band of the cornea free and diaphanous enough to see the iris.

On the inner side of the cornea, nearly in the horizontal meridian, but within this leucomatosus spot, was a perforation, with a rounded bead-like prolapse of the iris, the size of a pin's head—one millimeter in diameter. This staphyloma appeared perfectly black, and stood about a good millimeter above the surface of the cornea. The mother declared that the white "scum" on the eye, and the little black spot on it, had been there for the last five days.

As the examination of the eye seemed to have caused pain, and to quieten the child, I put one of the cocaine gelatine discs of Savory and Moore into the eye, and advised the mother to call next day for further treatment. The child had no bandage over the eye, nor did I advise any, except a very light one to guard it against dust and draught, though the eye was usually most firmly closed by the patient.

Next day, about 24 hours after I first saw the case, Dr. C. and I proceeded to give the child chloroform, to ascertain more precisely the state of the eye, when, to our astonishment, the prolapse of the iris had completely disappeared. Dr. C. had seen the staphylooma as well and plainly as I, but even under chloroform, with the help of the speculum, we could detect nothing but a fissure or rent in the place where it had been. This rent was nearly two millimeters in length, shaped somewhat like this , with insloping edges, and exactly on the same spot where the prolapse existed the day before. In the general appearance of the eye nothing was altered. I believe that the disappearance of the prolapse of the iris was caused by the lessened tension of the eye brought about by this application of cocaine.

Rockhampton, Queensland, May 26, 1887.

CASE OF SUPRAPUBLIC LITHOTOMY. —DEATH OF PATIENT WITHIN 24 HOURS.

BY H. V. DREW, M.R.C.S.E.,
RESIDENT SURGEON OF THE TIMARU HOSPITAL
(CANTERBURY), NEW ZEALAND.

My patient was a prematurely old man of 51, and had been cut for stone a year previously—the median operation having been the one selected. When he came in to hospital he was worn out with suffering, extremely thin and sallow looking, suffering from "stinking" cystitis, and an evening temperature ranging from $101\frac{1}{2}$ ° F. to 102 °. He was very anxious to have the operation performed at once, but as I did not like his appearance and condition, decided to postpone it and in the meantime try and improve his condition by relieving his cystitis. Treating the bladder was continued for about a fortnight with very little success, and at his urgent request operation was decided upon. Lithotomy was first thought of, but put aside as likely, in unskilled hands, to greatly aggravate the already greatly diseased condition of the bladder. Lithotomy, lateral or median, were put aside on account of the risk attending even a small loss of blood in a man in his low condition. The suprapubic was left, and as this is being extolled as extremely easy and favorable in its results, it was decided upon. But an unforeseen difficulty presented itself later in this case which could not have been reckoned upon, it was this : the effect produced by the anaesthetic operation. Patient was given ether first, but it produced such an unpleasant effect that chloroform was resorted to—whilst perfectly unconscious he remained absolutely rigid, and no "pressing" it

altered this condition. Chloroform was then given, but he did not take it at all well, and could not be got well under so as to relax the abdominal muscles. The spasm was so violent that it was with extreme risk that the bladder was pumped full of boracic acid and glycerine (after having been thoroughly washed out with the same lotion), and a tape tied round the penis. The pubis having been shaved and cleansed with carbolic and carbolized oil—an incision was made in the middle line, about three inches long, commencing immediately above the pubis. The linea alba was divided, and then the fingers used to get to the bladder, which was easily reached. (Now the stage was arrived at, which, should I have an opportunity of repeating the operation, I shall do it with this modification, i.e., I shall pass a needle through the edge of the incision in the abdominal wall, armed with stout carbolized silk, through the bladder, and through the other edge of the incision, at one end of the incision, and repeat the operation at the other end. In fact, the same as is done in colotomy. I do not know whether it would be possible to do the lithotomy in two stages as is done in colotomy, i.e., getting union to the abdominal wall before opening the bladder, and in the meantime draining the bladder with a catheter tied in ; but, in any case, it would greatly facilitate suturing the bladder after the removal of the stone). The bladder was now opened by a very small incision, and two stones the size of walnuts removed, the bladder was washed out with tannic acid to stop bleeding, and the clots were removed by injecting the boracic lotion through a catheter, and a large catheter tied in, in the usual way. The next thing was to suture the wound in the bladder, and two things tended to make it very difficult : 1st. The rigidity of the recti, which apparently could not be overcome though the man was deeply, almost dangerously, under chloroform ; and, secondly, the very bad light, as our operating room was not ready for use. Continued efforts were made but it was found impracticable, so a drainage tube was put into the wound down to the opening in the bladder, and the wound in the abdominal wall was sutured round the tube. The man did not rally properly, and died in twenty-four hours. The bladder was drained the whole time by a catheter, to which an indiarubber tube was attached to conduct the urine into a vessel below the bed.

Post-mortem.—The abdominal cavity was not opened during the operation, so the peritoneum was not wounded. The wound in the bladder had adhered, and had to be opened with the finger. The bladder (interior) was purple-gray in color, and in a foul sloughy state, and horribly fetid. Death was attributed to shock.

REMARKS ON ANTI-PYRINE AND ANTI-FEBRINE.

By T. CARSON FISHER, M.D.,
House Physician, SYDNEY HOSPITAL.

THE history of medical discoveries usually has three stages.

1st.—The period of extravagant laudation.

2nd.—The period of inconsiderate obloquy.

3rd.—The period of judicious use, or disuse, when the voice of experience proclaims the true merits of the case, or banishes it to the obscurity from which it sprung.

Every year we see this exemplified in therapeutical discoveries. New drugs have their fashionable period, their time of decadence, and finally they either enjoy a limited use, or they are allowed to sink into oblivion. Recently much attention has been directed to anti-thermic remedies, of which there are quite a list. In the phenol group are salicine and resorcine; while quinine, kairine, thalline, and anti-pyrine belong to the chinoline series. The use of quinine in ague, and the salicylates in rheumatism are already matters of history. They have survived the first two stages.

But the restless energy of anti-thermal medication demands newer drugs, and so the list increases. Accounts are published of their wonderful properties, of their power to cool the fevered brow, and calm the beating of the excited heart, until one would almost believe that a new era in the treatment of fevers had come, in which these medicines would play the part of "ministering angels."

We read of the virtues of anti-pyrine in typhoid and rheumatic fevers, in pneumonia, bronchitis, in the exanthemata and pyrexias of childhood. Such anti-pyretics are fashionable; they are still in the first stage of their history.

Those of highest repute are anti-pyrine and anti-febrine, and as I have frequently had opportunities of watching their effects, a brief account of them may be of interest.

Anti-pyrine, chemically termed dimethyloxy-chinin, is a synthetically prepared alkaloidal compound. It is a white crystalline powder, readily soluble, has little odour, and "a mildly bitter taste."

The last characteristic had better be taken *cum grano salis*. Dose, grs. xv—xxx, or more. I have usually seen it given in two doses of grs. xv each, given after an hour's interval.

The drug has the power of reducing temperature from 1 deg. up to 5 deg. or 6 deg. F. in fevers, such as typhoid, pneumonia, &c. Its action is rapid, nearly always shown within two

hours; the full effect being reached in two to four hours, and in exceptional cases beyond this up to eight hours. Sweating frequently goes with the lowered temperature. Its effect on pulse or respiration is not very marked, given in the above doses.

The temperature remission is very short; the line of ascent is very similar in height and duration to the previous descent.

Its disadvantages are its nauseous taste, its evanescent action, an occasional rash like measles after prolonged administration. Very often nausea or vomiting, or profuse sweating. Once I have seen a state approaching collapse, marked by cold and profuse sweating and a feeble, rapid pulse in a case of enteric fever, after one dose of grs. xv. Stimulants soon improved the condition. Several cases of death after taking the drug have been recorded.

Whether the merits of this medicine outweigh these disadvantages is at least questionable. Anti-febrine is a recent anti-pyretic. Its chemical name is acetanilide or phenylacetamide. It is a white crystalline powder, freely soluble in alcohol, taste not unpleasant. Dose, grs. v—xv. It is about four times as strong as anti-pyrine, and has a similar effect on temperature. I have seen it given chiefly in single doses of grs. v, which in nearly every case caused a rapid fall of temperature, reaching the maximum in two to four hours in 70 per cent. of cases. In 52 per cent. the reduction was from 2 deg. to 4 deg. F.; in 26 per cent. from 4 deg. to 6 deg. F. In only 6 per cent. was there no fall of temperature, and in these instances it was given before the evening rise in typhoid fever, and apparently prevented the rise for some hours. In several other cases it did lower the evening temperature. The period of remission was very short. Like anti-pyrine, the line of ascent was similar in height and duration to that of the previous descent. This occurred with the utmost regularity. In 52 per cent. the after rise was from 2 deg. to 4 deg. F., corresponding with the descent. The time to the lowest temperature was two to four hours in 70 per cent.; in only 8 per cent. did the fall last more than four hours. In 40 per cent. the temperature rose again nearly to a corresponding height in two to four hours. In 28 per cent. the rise lasted above four hours.

The effect on pulse or respiration was not remarkable. I have never seen any unpleasant effects after anti-febrine. Neither rash, rigors, sweats, vomiting, diarrhoea, or collapse were observed. Patients sometimes complained of feeling cold, but did not shiver.

Comparing the two drugs, anti-febrine is more pleasant to take, one dose of grs. v produces

effects equal, if not superior to grs. xv—xxx of anti-pyrine, while it has none of the unpleasant effects of the older drug. The action of both in rapidly reducing temperature is evanescent, although the regularity of the curve of fall and rise is very remarkable, both in a pathological and therapeutical point of view. To those who believe in the necessity of anti-thermal medication when the temperature rises above a certain limit, these drugs are certainly valuable. Their action is more certain than cold sponging, or packing, more rapid and reliable than large doses of quinine, and less troublesome to patients and attendants than the cold bath.

But such considerations lead us into that dim region which science has yet hardly explored. Physiology inadequately explains the mystery of the normal temperature and its mechanism; while its disorder in fevers is the battleground for rival theories.

The thermometer tells the clinical student the changes in temperature, and the various types of temperature curves which mark the different fevers, but it cannot inform him what part of the heat-regulating mechanism is disordered, or even whether fever exists. To quote a recent authority—"High temperature is not necessarily fever, and fever is not necessarily accompanied by high temperature. We may have a *febris sine febre*, a morbid thermogenesis, without high temperature, the increased heat production being compensated by increased heat loss. And we may have a rise of temperature even with diminished thermogenesis, if the heat loss is so diminished as no longer to balance even the diminished production. The former would be fever, though the patient were cool, the latter would not be fever even though the patient were hot."—The difference between the rate of heat production and the rate of heat loss at any moment is measured not by the temperature, but by the gradient of the temperature."

How such anti-pyretics act is still a problem. If there is a nervous centre which regulates the mechanism of heat production and heat loss, as recent observations tend to prove, it is conceivable that such drugs can modify its action in fevers either by inhibiting heat production, or stimulating heat loss for a time, and so cause a rapid fall of temperature; while the regularity of the after elevation suggests that the thermo-tropic or heat-regulating mechanism still exerts its sway even amid the disorder of functions observed in fevers.

Medicines which have such powers demand at least careful attention, and offer promise of abundant scientific and practical harvest. Meanwhile their use should not be discarded because they

may not accomplish all that ardent and enthusiastic admirers report.

The second and even the third stage in the history of some of them has already been reached. Thalline, kairine, and resorcin seem on the descent to the limbo of forgotten remedies. Anti-pyrine and anti-febrine are still on their trial. The transition from extravagant praise to inconsiderate obloquy is hardly yet come.

INSANITY DURING PREGNANCY.

READ BEFORE THE S. A. BRANCH B.M.A.

By W. L. CLELAND, M.B., RESIDENT MEDICAL OFFICER, PARKSIDE LUNATIC ASYLUM; LECTURER ON MATERIA MEDICA, ADELAIDE UNIVERSITY.

THE following brief remarks have been suggested by the reports of suicidal tendencies in certain pregnant women, brought forward at the February meeting. In connection with the subject, it may be of interest to some of the members if the experience of the Lunatic Asylums of Adelaide be taken on the subject. These numbers will not give a correct idea of the frequency of insanity as a complication of the pregnant state, for without doubt a large number are treated in their own homes. There naturally exists a very strong prejudice against the idea of an infant commencing its mortal career amongst the somewhat melancholy surroundings of a Lunatic Asylum ward. It is too much yet to expect of the many that insanity as a disease should be placed by them on the same footing as phthisis, gout, or rheumatism, in so far that they all imply certain constitutional weaknesses. Fortunately for the insane, the opinion that insanity is simply a disease has long since become an axiom with the medical profession. And it is important to remember that not only is it a disease, but that it is essentially a product of family development. In this it differs materially from the chief epidemic and endemic forms of disease, which often are the direct outcome of filth contamination acting on perhaps the temporary lowered vital systemic tone of certain individuals. As in the case of gouty and rheumatic diathesis, familiars may grow into or out of the insane diathesis, but no one develops any of these diathetic conditions full-blown in his own person. Instead of being antagonistic it is essentially of an evolutionary nature. This leads to the opinion that in many diseases exciting causes in their production hold a distinctly secondary place, and this is essentially true of the exciting causes of insanity. Of these, none at first sight seems more strange than that such a natural process as being pregnant should become

an exciting cause. But if it is borne in mind that a very intimate connection exists between the highest developed nerve-centres and the generative organs, and if Hughlings-Jackson's three plains or levels of evolution of the central nervous system are accepted, it becomes more plain why physiologically active conditions of the uterus should often become a disturbing mental factor in women and not in lower animals. We may share tuberculosis with them but not insanity of the highest nerve-regions. This mental disturbance is a matter of every-day experience to those who have much to do with pregnant women, and the text books are replete with their morbid ideas, both motor and sensory, which presumably show a disturbed state of the cortical substance of the frontal and occipital lobes. Fortunately, this mental disturbance is, in the great majority of cases, of a functional nature, if by functional is meant only such a disturbance of the histological elements as permits of a return to nearly the normal in structure. But whilst there is this important nervous connection between the uterus and the cortical substance of the brain as an exciting cause, there is another no less important disturbing factor, arising from the excretory apparatus often not being equal to the extra demands made upon it. The Ancients, with their usual insight, clearly saw a distinct mental connection between certain depressed states and an important action of the liver. This is shown in their employment of such terms as melancholia and hypochondriasis. It is probable that the great majority of women feel the extra excretory labour of purifying the blood of the fetus, for as a rule this period of a woman's life is certainly not the most becoming as regards complexion, i.e., if the excretory equilibrium is still further deranged, or if the highest nerve elements are less stable than usual, there may be all shades of peculiarity developed, and in some cases insanity will result.

As regards the causation of insanity in pregnant women, there are thus at least two well-defined exciting causes ready to act if the primary diathetic state is favourable to the production of insanity.

1st.—The direct effect of the uterine nervous activity.

2nd.—The undue accumulation in the system of material that should properly have been eliminated, causing a species of septic poisoning.

In the first class of cases, the insanity is generally of an excited nature manifesting itself in noise, destructive habits, intolerance of clothes, and often obscenity. It also is more likely to occur during the early months of pregnancy than the later.

In the second class of cases, the insanity is decidedly of a depressed form, manifesting itself by listlessness, suicidal tendencies, refusal of food, and general apathy to everything around. As a rule, this form will manifest itself during the later months.

Fortunately the prognosis in either class is favourable, if the diathetic condition is not too pronounced.

The treatment is necessarily very different in either class, and each case requires to be taken on its own merits, for in some patients both causations seem to be at work. For the excited and destructive class, the bromides, with occasional stronger alterative medicines, generally answer well, the object being not to cut short the attack, but to lead the patient *tute*, if not *cito et jucunde*, to that time when the exciting cause will have ceased to operate. For the mentally depressed, the bromides must be very carefully avoided. The drugs used should have for their object the stimulation of the excretory organs, more especially the liver. The costiveness, which is often troublesome, may be removed by the use of opium, thus showing that it arises from nervous sympathies with the uterus. The action of the opium on the kidneys and the skin is also otherwise beneficial; and its combination with ipecacuanha makes frequently a judicious mixture.

During the ten years ending Dec. 31, 1886, there were 819 female patients admitted into the Lunatic Asylums at Adelaide. Of this number 16 or 1·96 per cent. were in a pregnant condition on admission, and as no other assignable causation of the insanity was given, the uterine condition may be accepted as the probable one. Nine out of the sixteen were more or less in a state of mania or mental excitement; whilst seven were melancholic or in a depressed nervous state. Twelve out of the sixteen recovered, seven having been maniacal and five melancholic. Four did not recover, two having been maniacal and two melancholic.

Thirteen out of the sixteen were decidedly suicidal. Of the four who have not recovered the prognosis is not favourable, the insane diathesis, judging from family history, being somewhat marked. With the help of the asylum surroundings, three out of the four are as a rule fairly rational and able to employ themselves, but if exposed to the ordinary worries of life would speedily relapse into some acute form of mental disorder.

The above summary seems to show that heroic remedial measures are not indicated; and if the home surroundings are not compatible with the safety of the patient, advantage should be taken of the accommodation provided by the State.

TUMOUR OF THE BRAIN.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH,
B. M. A.

By A. A. HAMILTON, M.B., ADELAIDE.

K. M'L. aet. 47 (1887), blacksmith, single. Family history good; no hints of syphilis. In good health till January, 1884, then had two epileptiform fits in rapid succession. Came to Adelaide, and was under treatment by Dr. Thomas for some time. After an interval of about one year the fits returned. Early in 1885 a fit occurred late one evening, and next morning he found that he had partially lost the use of the left arm and leg. With this exception all the fits occurred in the day time. He then went into the Adelaide Hospital, and I am indebted to Dr. Lloyd's kindness for obtaining for me the notes of his case while in that institution.

K. M'L. was admitted May 30, 1885, aet. 42, single, blacksmith, born in Scotland; 11 years in colony. Complains of occasional epileptiform fits and weakness of left side. No history of syphilis. Marked loss of power in left arm and leg. Increased tendon reflexes on left side. Bowels constipated.

June 6.—Had a fit (not described).

June 16.—Had another.

June 29.—Had improved considerably.

July 2.—Again had a fit, preceded by painful sensation of left side. Increased loss of power on left side. Discharged July 7 in that year.

Treatment.—Thinks himself that for a short time the arm and leg improved, but soon began to grow decidedly worse. First seen by me in February, 1886. The power of the left arm and leg was very much impaired. Still able to walk with the aid of a stick, though very slowly. Complained a good deal of darting pains which shot through the left arm and leg, especially just before the occurrence of a fit. The epileptiform fits at this time were occurring at intervals of 8 to 10 days. Left patellar reflex exaggerated; urine normal.

Eyesight slightly impaired; heart healthy. Under full doses of the mixed bromides and ergot the intervals between the fits increased considerably, and the darting pains became much less severe. For some months he remained in pretty much the same condition, continuing the bromides and ergot mixture, and regulating his bowels, which always tended to constipation, by small doses of magnes. sulph. taken early every morning.

July, 1886.—Seen by Dr. Thomas with me. The leg and arm were now decidedly weaker, and the hand and foot slightly oedematous. No optic

neuritis. No facial paralysis. Field of vision fairly normal.

At Dr. Thomas's suggestion pot. iodid. was administered in gr. The fits, however, became more frequent, and we had to return to the bromides and ergot mixture, which again controlled them. I subsequently added pot. iod. to this mixture.

Sept., 1886.—Loss of power almost complete in affected arm and leg. Can only move about with great difficulty with the aid of a crutch. Fits and darting pains almost quite stopped. Memory impaired; intelligence dull; no complaint of headache at any time. Complains of pain in the back of the neck, which was caused by the head sinking forward on the chest, and relieved by a pad adjusted under the chin. Loss of sensation in back of affected hand and impairment of sensation on instep of affected foot. Hand and foot much more oedematous. Muscles on paralysed side flabby but not much wasted. Nails on affected hand much curved, and fingers bulbous. No tenderness or percussion over any part of skull; no optic neuritis; no facial paralysis.

Sept. 16.—Had some difficulty in passing water last night.

Oct.—A few fits of a light character occurred, preceded by a "sensation" (not pain) passing upwards from the affected foot. These attacks were completely controlled by tightening a strap worn round the thigh for the purpose, on the first approach of the aura.

Nov.—Complains for the first time of slight headache in the parietal region of the right side. No tenderness or percussion. Became gradually more helpless, and in the latter part of December sank into a state of coma, which lasted till his death, three days afterwards. At the P.M. examination of the head which Dr. Thomas kindly assisted me to make, our diagnosis of tumour of the brain was verified. As you may see from the specimens which Dr. Thomas has kindly brought with him, there is a tumour in the R. hemisphere, in front of the upper extremity of the fissures of rolando, occupying the upper end of the ascending frontal convolution. As no section has yet been made I regret that I cannot give you any information as to the nature of the tumour.

In this case we may note the absence of many of the symptoms most commonly found in tumours of the brain, viz.: severe and persistent headache, vomiting, and optic neuritis. Tenderness on percussion of the skull over the site of the tumour, which has been noticed in some cases, was also absent. Headache was altogether absent till about a month before death, and was then slight. My excuse for taking up the time of this Society with a case which does not present

any very striking features, is the keen interest with which we must all have watched the recent brilliant triumphs of brain surgery at home. The question of operation was discussed with Dr. Thomas in this case, but while the matter was under consideration, coma supervened, and the idea had to be given up.

A CASE OF HÆMOPHILIA.

READ BEFORE THE MEDICAL SECTION OF THE
ROYAL SOCIETY OF N.S.W.

BY JAMES GRAHAM, M.A., M.B. (EDIN.), MEDICAL SUPERINTENDENT, PRINCE ALFRED HOSPITAL, SYDNEY.

A CASE of Hæmophilia, with the characteristic knee affection, the nature of which was only fully brought to light in the course of treatment of what, from the patient's own statement, seemed to be a simple case of synovitis, may, I hope, be considered sufficiently interesting to bring before you, not only from its comparative rarity, but also from the temptation that naturally exists to overlook the cause of such a lesion.

The patient, a fairly strong looking lad of 20 years, sought admission into the Prince Alfred Hospital for treatment to his left knee-joint. He was under the care of Mr. Hankins, to whom I am indebted for the privilege of bringing the case before you. There was nothing to distinguish the condition from a case of simple effusion, and as the patient's statement corresponded to the history of uncomplicated synovitis, it was readily treated as such. He had knocked it against a stone three weeks previous to admission, and the swelling which immediately appeared had persisted. The patient gave no history of congenital enlargement, which further enquiry fully established, only, however, after intercurrent symptoms had demanded such a diathetic cause to explain them. As the large effusion showed no signs of subsiding under the ordinary pressure treatment, I introduced into the joint a fine aspirating needle and drew off about two ounces of what seemed at the time to be synovial fluid; it was not subjected to microscopic examination, as there was nothing to lead me to expect the diathesis. I was called shortly after, on account of the profuse bleeding which was coming from the punctured wound, not in spurts or jets, but in a continuous stream, as if from an over saturated sponge. It refused to stop for some hours, and next morning the joint was so full of blood, and the interstitial haemorrhage so great, that the conditions really looked alarming.

There was no doubt now as to its being a bleeder's joint, and the family history settled the question. He was one of 10 children, of whom four were living. One brother had bled to death from a comparatively trivial wound on the foot, inflicted by the bite of a rat. Another brother, two years older than the patient, had bled for two months on several occasions, once after having a tooth extracted, and on another occasion from an injury to his finger. There are two living daughters in the family, neither of them are known to be bleeders. One has been married for eight years and has six children, none of whom are known to be similarly afflicted. The mother has been dead for 16 years and there was no history of any of her relations afflicted with hæmophilia. The father is strong and hearty, and quite free from the diathesis, and knew very little about the earlier branches of his own or his wife's family.

I have the patient, along with his brother, here to show you. You will notice that they are both very much impaired in their locomotion, and that it is owing to their inability to flex, to any extent, their knee-joints. None of the legs can be bent at more than a right angle, and the elder of the two walks so badly, that he is unable in consequence to earn a living. One joint is full of fluid, another has marked destructive changes in it, like that of osteo-arthritis, while the other two show signs of chronic thickening. At times they have felt, on taking any form of violent exercise, that their other large joints are for some time after stiff and painful. They are both in appearance very like each other, so much so as to be taken occasionally for twins. They are of fair complexion, with dark blue eyes, and wide pupils; the skin of the face is slightly freckled, but otherwise there is nothing specially to note about them, and organically they are sound.

The hemorrhagic diathesis is described as the most hereditary of hereditary diseases, and it has long been known that the tendency to protracted or fatal bleeding after trivial injuries, and even spontaneously, runs in the line of certain families.

In one case, recorded as far back as 1803, the tendency was shown to exist for 70 or 80 years.

There is also reference made to something like it by a physician of the 12th century, and translated under the head of *De passione fluxus Sanguinis*. But notwithstanding the marked fecundity of all bleeder families, and the great hereditary tendency of the condition, hæmophilia does not seem to have laid much of a hold upon the race, owing, no doubt, to the tendency for abatement of the symptoms, which grows with the age of the bleeder, and also to the great mortality of bleeders, and to the fact that the males of the family do not, as a rule, transmit it. The con-

dition itself, however, still remains a pathological mystery. In the present case there was no sure means of getting the chain of evidence as to heredity, as there was a lack of intelligence on the part of the father, and the patient himself knew little or nothing about his own relations. Still there is the direct evidence of the congenital and habitual haemorrhage in three male members of the family, and an absence of it in the female branches, the combination of the three factors being insisted upon as constituting the chief characteristic of the disease.

Out of a total number of 650 bleeders, whose cases have been fully ascertained, they were found to belong to 219 families, giving three to every affected family. This number holds good in the present case.

The average number of children stated as belonging to the haemophilic families is 9·5, whereas the normal average born in wedlock is about 5.

The patient was one of 10 children.

The proportion of male to females affected is as 13 to 1. Where males and females are alike affected in the same family, the number of males far exceeds that of the females. There are three cases recorded where the daughters alone were affected. The interesting anomaly is apparent, that the females are in reality the most intensely affected, for they alone, as a rule, transmit the disease to their own offspring. Males who are bleeders do not beget bleeder children by women who are of non-bleeder families, whereas on the other hand, the offspring of women who are themselves bleeders, have generally the diathesis. The first bleedings of haemophilia, in the great majority of cases, occur in early childhood. The separation of the umbilical cord has not been referred to as a source of special danger in a child bleeder; the most common time for the full outbreak is at the end of the nursing period, probably owing to the child then becoming more exposed to injuries. With the advance of age there is generally a decline in the intensity of the symptoms, and very frequently the tendency may disappear altogether. There is no determined physiological constitution common to this affection. The colour of the hair, iris, and skin, is sometimes referred to as present in the diathesis, e.g. fair hair, blue eyes, and a pale skin. In the present case the hair is light, eyes dark blue, and about the skin there is nothing specially noticeable.

The exact determining cause still remains unknown; most frequently the haemorrhages are induced by injuries of the most insignificant kind, which would appear so harmless in healthy persons, as to scarcely attract attention. It is stated that the danger from the same kind of wound is not equally great at all times; also that the occurrence

of a traumatic haemorrhage may awaken a latent diathetic tendency. Haemorrhages may arise spontaneously, from any mucous or serous surface, without any exciting cause or predromatic. On the other hand such haemorrhages are often preceded by certain well-marked symptoms, such as flushings, a sensation of heat, and forcible pulsations of the heart and arteries. The mode of escape of blood seems to be in a continuous stream. It is poured out usually under a very strong pressure, judging from the rapidity with which a large quantity of blood is lost. On attempting to control the bleeding by pressure, an interstitial ecchymosis soon arises, which, in the case of this patient's knee, looked alarming from its dusky colour.

A special feature noticed is the tolerance with which bleeders bear great losses of blood, and the rapidity with which restitution is brought about. One patient lost three gallons in 11 days, another two quarts for several days in succession. The blood itself shows nothing abnormal about it, either in its colour or coagulability. In some cases it has been noticed that the red corpuscles are present out of all proportion to the white, in several cases as 15,000 to 1. This would point to a condition of plethora, and so favour such a theory as a cause of haemophilia.

Interstitial bleedings usually occur over regions which are most apt to be subjected to pressure, but they are out of all proportion, usually, to the force of their exciting cause. Apart from the bleeding symptoms, there is nothing, usually, in the general condition of these patients that is abnormal.

Anatomically, however, it has been pointed out that in a series of cases, the lumen of the large arteries and their branches have been unusually narrow, and the walls of the vessels as thin as those of the veins. The hypoplasia being mainly in the tunica intima and media, thus reducing their natural elasticity. It has been noticed also that the spleen has been frequently found enlarged. However, these anatomical factors are evidently not constant, and to explain haemophilia in the vascular theory implies these conditions as a logical necessity.

The great frequency to rheumatic affections, as neuralgia, toothache and rheumatic arthritis, would point to a neurotic influence at work in the diathesis. Toothache probably is one of the most common affections in the bleeders, and it is the extraction of a tooth, often, that may lead to alarming or even fatal haemorrhage. In the case of the bleeder referred to here, it was from the extraction of a tooth that he nearly lost his life, and a similar fatality, from a similar cause, nearly befel his brother.

The absence of the bleeding tendency in females has been explained by the tendency there is to the less hypoplastic state of the blood system, aided at puberty by the constant drain from the menses, which may or may not be excessive, and the tendency for the haemorrhages of the bleeder character to become less and less severe as age advances, has been explained on the ground of the haemato poietic system becoming less and less vital in its work.

It remains to be stated that the minor operation of vaccination has not been attended with a high mortality, for the reason, no doubt, that it is often done without drawing blood.

The large joints are very often the seat of haemorrhages into their synovial cavities. In this particular case both of the patient's knee-joints were distinctly larger than naturally.

Dr. Wickham Legg, who has given the most modern and complete contribution to the subject, describes the P.M. condition of two knee and one ankle joints. Of one knee-joint he says that "the connective tissue in the joint was deeply stained of a brown colour, but the changes in the cartilages were more advanced. On one side it had lost its attachment to bone, the edges were raised, and rugged, and fissured. Under the microscope the cartilage showed fibroid degeneration of the hyaline matrix, with multiplication of the cells, and breaking up of their capsules." In another case he reports that there had been a swelling of the right knee when the boy was a year and nine months old, and it had remained more or less marked. The patella was fixed to the front of the femur by adhesions; the cartilage in the patella had become absorbed and replaced by fibrous tissue. The changes, Howard Marsh adds, "were no doubt due to the results of synovial haemorrhage, which produce more or less articular swelling, and followed by a low form of inflammation and the development of adhesions, and also by degenerative changes, consisting of fibrillation and absorption of the cartilage, and other changes, closely resembling those met with in osteo-arthritis."

Suppuration very rarely, if ever, occurs.

This patient's knee-joint ran an uninterrupted course. The rate of absorption of the extravasated blood seemed quicker than one would have expected from the extent of such a haemorrhage, even in a healthy subject, and to-night, as you have seen, it presents the appearance of chronic thickening. The family history is, perhaps, not so complete as to characterise this particular case as a perfectly typical one, still the major features of it perfectly justify it in being recorded as a true case of haemophilia, and I have brought it before you with the view of raising some discussion on

its pathology, and perhaps the influence of heredity on disease, of which the haemorrhagic diathesis is a good example.

A NEW EPIDEMIC.

BY T. F. MACDONALD, M.B. ET CH. M. GLAS.,
MEDICAL OFFICER PROSPECT WATERWORKS,
NEAR LIVERPOOL, N. S. WALES.

In January last a disease of rather an unusual and striking character made its appearance among the inhabitants of Prospect Reservoir Camp.

The rapidity with which it spread, its limited duration, and sudden departure, almost conclusively point to the fact of its being of "specific" origin.

Resembling in many respects what might be considered a modified form of influenza, yellow or malarial fevers, I was at first inclined to believe that such was its nature, but from observation of some sixty cases I am quite convinced that the symptoms are those of a disease hitherto, as far as I can learn, unobserved, or at least undescribed.

It confined itself almost entirely to men employed upon the works; the exceptional cases, however—two women and two children—being those in which the greatest degree of severity was observed.

General Symptoms.—Vomiting after food was invariably the first symptom complained of, but constipation, more or less, although often unnoticed by the patient, always preceded vomiting; lumbar pain, headache, loss of appetite, and excessive languor then followed, but on the second, third, fourth, or fifth day of indisposition jaundice appeared in the conjunctiva, and rapidly spread over the whole body. This is the symptom which most particularly identifies the disease—it was present in every case, and always in a very acute form. The yellow colour seemed brighter than that generally observed in those cases of jaundice arising from disease of the liver. Following the jaundice came symptoms of a febrile nature: great weakness, hot skin, rapid pulse and breathing, and high temperature. In the majority of cases, about the tenth day, sweating occurred, which seemed markedly to relieve all symptoms, and the patient rapidly recovered. The urine always gave characteristic evidence of abundance of bile—yellow green or brown in colour, with yellow froth; nitric acid giving the usual play of tints. There was great variation in degree of the above symptoms, but vomiting, languor, jaundice and sweating were always present.

The following cases are given as typical:—

I. Miss M. L., æt. 18 years. Jan. 23—Found patient in bed, suffering from following symptoms: High fever, 103° T.; P., 130; great

prostration ; pain over liver increased on pressure ; constipation ; weary expression in face, and dull typhus appearance in eyes ; headache ; whole skin completely jaundiced, conjunctive, finger and toe nails being of a bright yellow colour, contrasting with darker hue of skin ; urine loaded with bile, very dark, greenish brown in colour, with yellow froth ; gave reaction of bile pigment.

History : Had been five days in bed ; sickness came on with vomiting, while at school, followed by great weakness, felt more particularly in walking ; lumbar pain ; dull pain in right side ; feverishness and headache ; on the fourth day eyes became yellow, and next day jaundice appeared over the whole body.

Treatment : Prescribed purgatives and enemata with desired effect ; anti-pyretics and local treatment for pain were also used ; diet as in typhoid fever. Fever increased for two days, when delirium was present, and patient became very low, being with difficulty induced to take food ; stimulants were now used ; on the tenth day sweating set in, and from thence forward patient slowly recovered. Jaundice was present in a slight degree for many days after getting up. She recovered her normal strength with difficulty.

II. Mrs. C., *æt.* 32.—Saw her March 3 ; confined to bed with high fever ; P., 112 ; T., 102 $\frac{1}{2}$; headache ; vomiting ; great thirst and constipation.

History : Five days previous abortion had taken place, and she had been in bed since then. Examined, but found nothing wrong locally ; prescribed purgatives and enemata, with sponging ; next day found her jaundiced ; skin very hot and dry ; tongue coated with typhoid-like fur, but red at edges ; feeling very weak ; stimulants were given ; following day she was delirious, but sweating took place in the evening, and in two days she was much better. Jaundice did not go away till three weeks afterwards.

III. Mrs. C., *æt.* 30.—On the 26th January was seized with severe vomiting, headache, and high fever. I found her next day in premature labour, and very weak ; T., 104° ; pulse, quick and thready ; child was born same day (8th month). 28th.—Fever continued ; skin hot and dry ; constipation and lochial suppression were the prominent symptoms. Treatment was adopted in accordance therewith : enemata, syringing and fomentations locally, while morphia and digitalis were given internally. On the 30th, jaundice appeared as in above cases ; high fever continued for eight days, delirium being present, more or less, after the third day ; with profuse sweating the temperature rapidly fell. This patient regained strength very slowly, and the child at present is little more than alive, all attempts to

induce nutrition by artificial food, &c., having proved unsuccessful.

IV. P. I. S. (a very mild case), *æt.* 15 years. —Saw him on Monday, March 9 ; did not seem very ill.

History : On Thursday previous had slight vomiting with great nausea, preceded by constipation : sickness continued on Friday ; on Saturday morning jaundice suddenly appeared ; on Sunday vomited some bitter fluid, after which jaundice went away as suddenly as it came. No relapse of sickness took place.

This was the mildest case observed, and would point to simple intestinal or liver derangement, but occurring at the time when the above epidemic was prevalent, I consider it a mild form of same disease.

A brother to the girl given as case No. 1 also took the disease three weeks after his sister had recovered, but it was of a comparatively mild form, lasting only eight days.

It may be interesting to note that this disease occurred at a time when the people were in a very miserable condition, having little money to buy food, their tents were damp from the weather, and altogether they were very "unhappy."

Typhoid was absent from the camp during this period, but I may mention that, subsequently, I observed slight jaundice present in one or two cases of that fever which came under my care.

APHASIA, FOLLOWING FRACTURED BASE OF SKULL.

READ BEFORE THE N. S. WALES BRANCH B.M.A.
By M. ASHER, L.R.C.S.I., L.K.Q.C.P., IRELAND,
of LITHGOW, N.S.W.

In submitting the following case for the consideration of the members of this branch, I do so under the impression that the subsequent development of sensory aphasia—and that symptom only—following a coarse lesion of the nature described, is an uncommon one, and worthy of record.

The history of the case is, briefly :—A man, J. P.—, aged forty-six, returning home on horseback, intoxicated, whilst turning a corner rapidly, fell off on to the vertex of his skull on a very hard road. He became unconscious immediately, and bled profusely from left ear. Attending him very shortly I found the bleeding continuing—this gradually lessened, and stopped in about thirty-six hours—at first bright in colour ; subsequently appearing like cerebro-spinal fluid mixed with blood ; no clear fluid appeared. There was slight paralysis of face (left) ; contusion and œdema of both upper and lower eyelids, conjunctiva (not in upper part), over mastoid process and down the neck, appearing in about twenty-four hours ; the

pupil of left eye was very irregular—sometimes contracted, at other times dilated—the right pupil not corresponding with these changes; pulse, 44; temp., below normal; resp., 14. Extensive abrasion of skin over vertex, but no perceptible fracture; no paralysis of limbs. The mental condition from the first was one of extreme irritability; he persisted in burying his head in pillow and raising body, as though endeavouring to turn a somersault; at other times coiling head and body in a circle, lying on right side; was quite unconscious to all around, and required, for three days, two male assistants to keep him in bed; was unable to swallow food or purgatives; there appeared complete anaesthesia of pharynx. The mental irritability gradually decreased, and he was soon able to be left with female attendant:

From the above symptoms, I believe I was justified in deeming the case one of fracture of base—in middle fossa—probably extending to border of anterior.

The paralysis of face and contusions disappeared in about a fortnight, and he then began to recognise his wife and some others. He occasionally complained of pain over left frontal. After five weeks his physical condition showed considerable improvement, and he had practically recovered, except a most marked condition of aphasia.

I noticed, early, that there was considerable hesitation in answering questions, and that the answers were always unintelligible; also that the patient knew this, and would appeal, by looks, to his wife to correct him.

On subsequent examinations I found that, while he understood spoken language, his power of volitional speech was erratic, also that of volitional writing—the only words he can write are his own names, and this he has only been able to accomplish quite lately, and after considerable practice. The faculty of copying written words is absent, likewise that of writing from dictation.

The power of reading aloud is in abeyance—occasionally he will read a word or two correctly, but when asked to spell it, or name any letter, he fails, and scarcely ever can repeat the word after a short interval. The defect, thus, is intellectual, and not visual.

Memory of names, places, and things, etc., is absent. When told the name, etc., he at once recognises from others, and will repeat the correct word, but after an interval is unable, voluntarily, to do so.

Previous to the injury (Jan. 17, 1887) he was a very intelligent man, a tailor by trade, and lately, on one or two occasions, he has attempted to "cut out" clothing, and succeeded in doing so fairly correctly, but at other times the measure-

ments were inaccurate. Whenever I tested him with measurements or figures he failed.

This case will be recognised as one of almost complete sensory aphasia; the only point that redeems the patient's condition from one of intellectual blank is the retention of *understanding* what he sees and hears.

The point of interest, as before stated, is the apparent concentration of a very coarse and extensive lesion in a clinical result, which pathology and experimental physiology would lead us to believe is usually caused by small, if not minute, vascular changes. Again, if this presumably large lesion involves Broca's convolution, why are those motor areas, supposed to be so intimately adjacent and governing movements of tongue and lips, intact? Although carefully looked for, there was, at no time, any paralysis or excessive mobility of tongue or lips (except slight paresis of [left] oral muscles.)

The prognosis in this case can only be an unsatisfactory one. The treatment: rest, exercise and unexciting mental recreation; and I have advised the relatives to give daily lessons in spelling and reading, with a view of developing some compensatory action in the opposite (right) frontal convolutions.

A SIMPLE APPARATUS FOR GASEOUS RECTAL INJECTION.

BY BERNARD JAMES NEWMARCH, M.R.C.S. ENG.,
L.R.C.P. LOND., OF BOWRAL, NEW SOUTH WALES.

[Illustrated.]

THOSE interested in the treatment of diseases of the respiratory organs would do well to peruse Dr. Burney Yeo's admirable lecture, "On the New Method of Treatment of Consumption and other Diseases of the Respiratory Organs by Gaseous Rectal Injection," in *The Lancet* of April 16, of this year.

All new methods of treatment, especially one possessing marked disadvantages such as this does, are open to public disfavour and practical failure, either from want of knowledge or difficulty, and objection on the score of inapplicability and expense.

It is not within my memory, but I can quite conceive the difficulty that the medical man who first proposed and practised rectal injection had to overcome; and though years have made that operation common, and even popular, it still possesses obvious disadvantages. I can also believe that, if this practice of gaseous rectal injections for the treatment of disease is to be added, and become a common method of treatment with us, it will take years before either patient or

physician will really become convinced of the efficacy of a system which is stigmatised by one writer "as grotesque and repulsive." Still, it remains with us to attempt at all hazards to obtain relief, and it is those who submit to, and those who fearlessly carry out plans designed for that purpose, who most often meet with the success they deserve.

I carefully read the article I quote ; and meeting many cases where any treatment which could promise relief would be gladly accepted, I was determined to try the plan. The difficulty arose inasmuch as a case might present itself without my being furnished with the necessary apparatus ; to overcome this, I devised the apparatus here figured, and I trust I am not presuming when I write that if anything it is more simple and efficacious than the one figured in Dr. Yeo's article.

The apparatus required is, (1) a generator, (2) a reservoir, (3) a bottle to contain the medicated fluid, called a barboteur, and (4) an injecting apparatus.

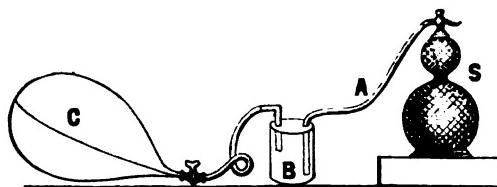


FIG. 1.

S Ordinary Seltzogene, to generate Carbonic Acid Gas.
A Connecting Tube to Barboteur.
B Barboteur containing Medicated Fluid.
C Reservoir.

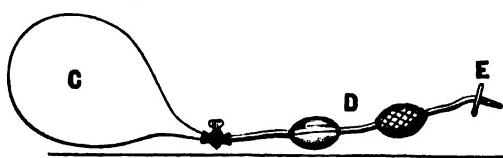


FIG. 2.

C Reservoir filled with Medicated Gas.
D Injection Apparatus.
E Anal Tube.

For the purpose of a generator, I have used an ordinary siphon soda water apparatus (Fig. 1), which most of us possess—(of course a simple generator can easily be made). The dry powders of carbonate of soda and tartaric acid are placed in the upper globe, a small quantity of water in the lower globe, and the cap tightly screwed down: by tilting the apparatus, the water can be made to flow in the usual manner into the upper, from the lower globe, leaving the latter nearly dry. Gas is formed at a very high pressure and, by the connecting tube (A) is passed through the barboteur (B) to the reservoir (C) which, when full, is closed by the tap and disconnected.

One now possesses a reservoir of medicated gas, which can be carried without inconvenience, and injected by an ordinary india-rubber ball-pump, such as is used for an ether spray producer.

The different parts of this simple apparatus have been obtained for me by Mr. Bruck, of Sydney, and though I cannot compare the cost with the apparatus depicted in *The Lancet*, since it is unknown to me, there is little doubt that it is cheaper in the form I have devised, and obviously more portable and convenient. Instead of carrying about what appears a somewhat cumbersome apparatus and chemicals, I advocate the charging of any number of reservoirs needed, at home; these can be conveyed to the patient, and the treatment carried out by any carefully instructed nurse or attendant; and though, as said before, it may take years to make the treatment familiar, and many more to make it popular, I believe that simplicity of apparatus will do much to effect the purpose if there is any value in this novel method of treatment. Whether it will be of real service is out of my power to say, but this I do say, that I respect the writings of my old teacher, Dr. Yeo, and, recommended as it is by the authorities he quotes, it is worthy of careful trial.

PREVENTING CONCEPTION.

By W. V. JAKINS, L.R.C.P., L.M., EDIN., FELL. OBST. SOC., LOND.

THE habit of preventing conception is, I regret to find, spreading very fast in these colonies.

Limited means, the inconveniences of a large family, delicate health, and the restrictions which pregnancy enjoins, are the commonest excuses given me for the practice of this habit.

Articles of common merchandise are now used for this purpose, resulting both directly and indirectly, but too frequently in ill-health.

I believe that it is natural for most women to conceive at stated times; in large families it is frequently noticed that a child is born every year and a-half or two years regularly—without hurt to the mother. Stop conception and the results commonly are—menorrhagia, leucorrhœa, especially severe before the menstrual period; ulceration about the os; fungosities in the canal of the cervix, sometimes also in the uterus; hypochondriasis, even to lunacy; and in protracted cases the uterus becomes enlarged, hard, almost stony to the touch, insensitive, os and canal dilated, the whole organ heavy and dragging upon its ligaments (with pains accordingly)—even to prolapse, and too often utter inability to conceive. Of course, many women escape these ills, yet often only for a time, and their onset is

so gradual, that treatment is seldom sought till the symptoms are confirmed. Perfect health under these circumstances is seldom attained, and a more or less life-long punishment comes to be the penalty for cheating nature. Undoubtedly it sometimes happens that we are compelled to prevent conception in cases where pregnancy is sapping the constitution, or is likely to terminate fatally, these occasions are to me very rare. Probably, were women adequately warned of the evils to be expected from this habit, they would desist from what might entail upon them years of suffering.

Similar remarks may be applied to the almost equally common habit of *inducing abortion*. There must be few medical men who are not frequently sought to thus assist in breaking the law. When self-induced, septicæmic symptoms are sometimes brought on, for a time closely resembling enteric fever.

The after effects differ somewhat from those cases where conception is prevented; there may be menorrhagia, leucorrhœa, hypochondriasis, and uterine enlargement, but not hardening, for the uterus is generally soft and flabby, the patient frequently makes flesh fast, becomes stout and short-winded, and is proportionately more inclined to excessive haemorrhage with each abortion. In other cases with the uterus large and soft, the patient becomes thin, even to emaciation—yet in both classes recovery is common after a full term parturition.

165 Collins Street, E., Melbourne, June 2, 1887.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 64th General Meeting was held in the Royal Society's Room, on Friday, 1st July, at 8.15 o'clock. Present—Dr. Chambers, Vice-President, in the chair; Drs. Ross, Knaggs, Hankins, Finschi, Clay, Crago, Brady, Newmarch, Worrall, Twynam, Kendall, Wm. Chisholm, Jenkins, West, Anderson Stuart, Martin, Wood, Foreman, Power, Bowker, and Scot Skirving.

The minutes of the previous Meeting were read and confirmed.

Dr Newmarch read some notes on a case of Lance wound of abdominal wall—strangulated hernia—operation—recovery.

The patient was exhibited and examined by the gentlemen present.

Mr. HANKINS said that this was an interesting and instructive case, but if put forward as a radical cure he (Mr. Hankins) must take exception to it. This case appeared to be analogous to one of laparotomy, and in most cases of laparotomy it was not necessary for the patient to wear a truss. There was still a little thickening which no doubt arose from the catgut sutures not having been absorbed yet.

Dr. SOOT SKIRVING said that as he had seen this case

in company with Drs. McCormick and Newmarch, it would perhaps be as well if he gave some of the opinions he formed at the time. In going over the case with Dr. McCormick we felt that we were not justified in recommending operation, for although, when the wound was examined, it gurgled under the finger, and the gut was felt, still, it slipped back, and we thought it was reduced. In this case the urgent symptoms were masked by the exhibition of opium, and if he (Dr. Skirving) were to meet with such another case he would temporise as in this one.

After a few remarks by Drs. Twynam and Ross, Dr. Newmarch replied.

Dr. Newmarch then exhibited a simple apparatus for Gaseous Rectal Injections, obtained from Mr. L. Bruck, of Sydney.

Dr. Kendall read a paper on Uremia.

Dr. Crago read some notes on four cases of Uremia.

After some remarks by Drs. Brady, Chambers, and Newmarch, the discussion on these papers was adjourned until the next General Meeting.

Mr. Hankins exhibited some microscopic sections of hydatids.

The Chairman announced the following new Members—Dr. Huxtable, Sydney; Dr. Macdonald, Prospect.

MEDICAL SOCIETY OF QUEENSLAND.

THE ordinary monthly meeting of the above Society was held on May 12, in the School of Arts, Brisbane. Present: Drs. Bancroft (in the chair), Tilston, Taylor, Gibson, Lyons, Mullen, E. H. Byrne, W. S. Byrne, Owens, Little, Shout, Hogg and Love. Dr. Liddle of Melbourne, was present as visitor.

Dr. Hogg, of Goodna, exhibited—

(1.) Some specimens of trichocoecephalus dispar.
(2.) Some small liver-flukes which had been taken, *post-mortem*, from the gall-bladder of a Chinaman. They resembled the ordinary distoma hepaticum of the sheep, but were darker in colour and smaller.

Dr. Owens showed a microscopic section of a dermoid tumour, removed from the eyeball of an infant five weeks old. It had grown very rapidly, having more than doubled its size in a fortnight.

Dr. Gibson shewed a small uric acid stone, which he had removed by supra pubic lithotomy, from a boy 3t. 3.

Dr. GIBSON then read a paper on Supra pubic *versus* lateral lithotomy, with notes of a case. He said:—

"Mr. Chairman and Gentlemen,—My name is placed opposite a very imposing title to-night, viz.: Supra pubic *versus* lateral lithotomy. To exhaust such a subject would require a very long lecture, instead of the twenty minutes' paper to which I am supposed to restrict myself. I hope the paper itself will not take longer than my allotted time, but as I have a case to relate at the end of it, I hope you will bear with me if I trespass somewhat longer on your patience. I shall consider as shortly as possible the following points:—1. What seem to me the advantages and disadvantages of supra pubic when compared with lateral lithotomy. 2. Which operation should be preferred to the other in those cases where lithotomy at one sitting cannot be performed. 3. What reasons should induce a man who, as a rule, preferred one of the operations, to perform the other. 4. The influence the age of our patients should have upon our decision. I shall give the details of a case of supra pubic lithotomy which I had myself, which bears more especially upon this last question. As my whole surgical training has been conducted on strict antiseptic principles for dressing wounds, with, at the same time, opportunities for contrasting that system with what may, for con-

venience, be called the non-antiseptic system, it is not extraordinary that I never could see sufficient reason for the dread surgeons had of performing the supra pubic operation for the extraction of stone. And I distinctly remember a conversation I had in 1881 with Mr. Chiene, whose house surgeon I then was, in which I combated that dread, and told him I should perform the supra pubic operation on the first favourable opportunity. The paper which had a short time previously been published by Garson (1878) on the possibility of raising the prevesical fold of the peritoneum by a rectal tampon, very much strengthened my favourable opinion of the supra pubic operation. This paper of Garson's received very little notice, although two years later Peter-on, apparently independently, made the same discovery. Within the last few years, however, the supra pubic operation has gradually worked its way into practice. The effect rectal distension has in raising the prevesical fold of peritoneum has been abundantly proved by Mannheim on children, and by Fehleisen on adults, by means of frozen sections. I was fortunate enough to be present at the German Surgical Congress held in Berlin in 1885, when Fehleisen exhibited the frozen sections which he had made to illustrate this point. Plates of these sections have since been published, and have been reproduced, very opportunely, by Sir Wm. MacCormac in the *British Medical Journal* for last March. In case some members have not seen these plates I shall hand them round. Fehleisen's frozen sections illustrate every essential point, except the effect of a distended rectum upon an empty bladder. It is a great pity that he did not make a section to illustrate this, for after the stone is removed by the supra pubic operation, the bladder is practically in the condition of an empty one. Sir Wm. MacCormac attempted to ascertain this point, and found that a distended rectum has no effect in raising the prevesical fold when the bladder is empty; but I do not think his experiments can be taken as conclusive, since they were not conducted by means of frozen sections; and since we find that when a rectal tampon has been employed the peritoneum has seldom been seen even after the bladder has been emptied. It is important to note what Fehleisen has shown, viz., that by distending the rectum a very moderate distension of the bladder is sufficient to raise the peritoneum well out of reach. This is important, for a stone-containing bladder is seldom able to hold a large quantity of fluid. And it is also important to remember that a certain amount of fluid should, if possible, be kept in the bladder even after it is opened. I have dwelt upon the raising of the peritoneal fold, because I consider that our ability to do this, together with the possibility of employing antiseptic precautions, removes all objections to the supra pubic operation as a surgical operation. And we must remember that if antiseptic precautions are employed, provided that the urine in the bladder is free from putrefactive germs, an accidental opening into the peritoneum is almost certain to lead to no untoward consequences. I. Its advantages over lateral lithotomy:—It can be done antiseptically, though not in all cases. Everything divided can be seen before it is divided, and it is therefore not such a groping in the dark as the lateral operation. *No important structures are cut through, and there is, therefore, no danger of future stricture, nor of emasculation.* And with proper care no important structure is likely to be injured. Also any sized stone may be removed by means of the supra pubic incision. Its disadvantages are:—It takes a much longer time than the lateral operation. But as I once heard Sir Joseph Lister remark, "with chloroform and antiseptics we can, generally speaking, take our own time at a surgical operation." If there is

putrefactive cystitis, the drainage, which would be then most important, could not be so satisfactorily carried out as through a perineal wound; for I cannot look upon complicating the high operation by a wound in the perineum, unless in exceptional cases, as good surgery. II. Which operation should be preferred to the other in those cases where lithotomy at one sitting cannot be performed? I agree with the almost universal opinion in Germany and Austria, and the opinion which is now rapidly gaining ground in England, viz.: that where lithotomy at one sitting cannot be carried out, the high operation is that which should be performed, and I am inclined to go even further and to say that the high operation may, in time, even supplant lithotomy at one sitting. For two reasons—The all-round mortality from it will probably be less than the all-round mortality from lithotomy, and the risk of recurrence is less. III. The reasons which might induce a man in the habit of performing the high operation to employ the low one—would I think be—1st. A diseased bladder with ammoniacal urine, the result of putrefactive cystitis. 2nd. The age of the patient. If the patient were really old, some of the more potent objections to the lateral operation would be removed, and one advantage would be gained, viz., rapidity of operation. (b.) The reasons which would induce one in the habit of performing the low to choose the high operation would be: 1. A very large stone; 2. Numerous stones; 3. An encysted stone; 4. A large indurated prostate gland; 5. Ankylosis of the hip; 6. Rachitic pelvis. This last might prove an objection to one or other operation, according to the seat of greatest deformity. IV. The influence age should have—I am very strongly of opinion that except under very exceptional circumstances the perineal operation should never be performed on the young. For the risk of rendering the boys sterile is exceedingly great. Teewan was able to trace the history of only four who had been cut when boys, and had subsequently married, and all were childless husbands. Haemstadt, of Pottsville, traced 18, and only one had issue. Langenbeck considers subsequent sterility very common. For my part, I find it difficult to see how sterility, partial or complete, is escaped. One common ejaculatory duct must be divided, and the other must rarely escape injury. I can find nothing recorded as to the frequency of stricture after operation, but have little doubt that it must be common. The long continuance in favour of the lateral operation is one instance of the fact that surgeons are too much in the habit of looking only for a successful recovery from the operation itself, and too little to the subsequent life-history and well-being of the patient. Total extirpation of the thyroid gland is another instance. In the case of old men the risk of emasculation would not count; the risk of stricture would be slight, and the low operation would have the advantage of being more rapidly performed. It will have been seen that I nowhere question the great success of, and the small mortality resulting from the low operation; this success and this small rate of mortality being most marked in children, for whom I think the high operation should almost invariably be employed. But I do think that when such men as Sir Henry Thompson quote the all-round mortality from the low operation at 1 in 8·2, the improved high operation will have at least as low and even a lower mortality. As you will notice from the statistics in Sir Wm. MacCormac's paper, the results obtained by supra pubic lithotomy cannot be taken as reliable statistics for the future of the operation, as it is only now being perfected. Still the absence of mortality (in England) in children under the age of 15 years holds out a hopeful outlook.

NOTES OF A CASE OF SUPRA PUBIC LITHOTOMY.

By J. LOCKHART-GIBSON, M.D., EDIN.; FORMERLY SENIOR DEMONSTRATOR OF PHYSIOLOGY, EDINBURGH UNIVERSITY.

BRISBANE BROOKS, aged 3 years, son of healthy parents, a very well nourished, fat, healthy child, was admitted, January 28, 1887, to the Sick Children's Hospital, suffering from great pain after micturition and during the act, so that he dreaded to make water, which, owing to some irritation, had to be frequently passed.

He had been in the hospital a month or so previously suffering from the same symptoms, and on being sounded a small stone was discovered. The symptom then disappeared under benzoate of soda, and after a few weeks I sent him home to see whether medication might gradually lessen the size of the stone. He was well for a short time at home, but on the symptoms returning he was again brought to the hospital. The stone was still there, and I took it to be between the size of a pea and a broad bean. The symptoms disappeared again, and almost entirely, under benzoate of soda and hyoscyan. I endeavoured to get a small May's lithotrile to crush the stone, but was unable to get one smaller than a rather large 7, and his urethra would not admit that, although Keegan has shown that the urethra of some boys of 3 will easily admit a No. 7.

I therefore decided to do the high operation.

On March 2, with Dr. Love to give chloroform, and Dr. Hill to assist me, I first placed a small Barnes' bag into the rectum, and slowly filled it with $2\frac{1}{2}$ ounces of water. The Barnes' bag answered very well, but in future I would use a much shorter bag, as its end reached nearly to the umbilicus. I then introduced 2 ounces of warm boracic lotion into the bladder, after drawing off all urine by means of a red rubber catheter, withdrew the catheter, and tied the penis tightly with a piece of elastic tubing. The pelvis was elevated by a pillow. The bladder was felt distinctly distended, and pushed forward and upwards. An incision of about two inches was made in the middle line, immediately above the symphysis, the linea alba carefully divided, as much division as possible being done on a director, and then the fascia transversalis divided on a director. The extra peritoneal fat was also divided with the knife, two veins running upwards, one on each side of the middle line, being avoided. I was extremely careful to "go straight" for the bladder, and to avoid all lateral dissection. It is most important to attend to this point in order to avoid extravasation of urine into the cellular tissue. No peritoneum

was seen at any time during the operation, although my deep incision must have been an inch-and-a-half in length.

The bladder was fixed by a silk thread, on either side of the middle line, passed through its coat by means of a curved needle, and was then opened between these threads. I made the opening in the bladder large enough to admit my little finger and one blade of these forceps. The boracic lotion poured out of the wound, and the Barnes' bag pushed the posterior bladder wall up against the symphysis, thus introducing a difficulty, for the small stone was wedged in between the distended bag and the symphysis, and I had a little difficulty in removing it, which I did by means of my little finger and one blade of these forceps. Here is the stone. It is an unusually rough uric acid calculus, and weighs $16\frac{1}{2}$ grains, and is very much the size supposed from the sounding. The bladder was then washed out with boracic lotion (cold), three catgut sutures were introduced, care being taken to avoid inclusion of the mucous membrane in the sutures. At the time I hesitated as to whether I should introduce at least another stitch, and in future I would put at least six to the same size of bladder wound. A drain of chronic catgut was introduced well into the deep part of the wound, with an end appearing at either extremity, and the superficial wound was then stitched with double horse-hair, the lower end being left somewhat open. For dressing it was powdered with iodoform, and dressed with salicylic wool. The whole operation was done under the spray, and every care was taken to disinfect hands, sponges and instruments. The boy was placed in a double long splint, which I can strongly recommend for children, and upon his back, with head and shoulders raised, so that the whole body was on an incline. A well-padded bed-pan was placed in position, and a urine bottle also in position.

His hands were loosely tied to the sides of the bed. He was very comfortable !!

By these means it was possible to estimate accurately how much urine passed per urethram, and approximately how much, if any, passed by the wound.

He passed 7 drachms of urine per urethram at 10 p.m.

Prepuce was very oedematous, and required snipping, the oedema being due to the ligature which had been tied tightly round the penis. This oedema was, I think, the reason why no more urine passed per urethram until the evening of March 4, and why it came by the wound in spite of the stitching, which, as I said before, was not sufficiently complete. The urine came very readily by the wound, and the catgut drain acted as an excellent guide to it. On the day after the

operation, March 3, the temperature went gradually up to 102·2, which was reached at 4.30 p.m., after which, and possibly due to some liq. am. acet., it gradually sank to normal, which it reached next morning, March 4, which, to speak generally, it never afterwards exceeded, though on two subsequent occasions it reached 99°.

He had a little bathing for the first few days after the operation. He was fed for the first ten days on milk only. Urine was plentifully secreted and passed from the first. It contained traces of blood for the first two days. Had invariably a slightly acid reaction (the benzoate of soda and hyoscyan being continued). The wound was freshly powdered with iodoform twice daily, and dressed with fresh salicylic wool.

On 8th March, *i.e.*, the 6th day, his hand was loosened for a few minutes, and while the nurse was away he pulled the scab off the wound, which was healed, except at the lowest part, and with it the catgut drain. Luckily, the only ill effect this accident had, was to retard, somewhat, the complete healing of the superficial wound, for in pulling on the drain the freshly-healed wound was partly torn open.

On 5th March more urine came by the wound than by the urethra; on the 6th and 7th March, more passed by the urethra than by the wound.

8th March—Only once a little passed by the wound when straining at stool; after which, *i.e.*, after the 6th day, I could never satisfy myself that any urine passed otherwise than per urethram. The splint was kept on until the 17th March, as a small part of the lower end of the wound seemed to be pretty deep; after that they were removed, and he was allowed to sit up a little. On the 18th March, he was allowed to sit up in bed, and by the 22nd March, the wound was firmly healed, he was running about as much as he liked, and looking as well as ever he did. Had he not pulled out the catgut drain and partially torn the wound open on the 6th day, I have little doubt that firm healing would have occurred within the fortnight. As it was, I probably erred in keeping him in bed so long, but it was on the safe side, and at any rate, did no harm.

The only points which I would alter in performing the operation again are—

1. I would use a shorter bag for distending the rectum.

2. I would close the urethra during the operation by some other method; possibly by a catheter.

3. I would stitch the bladder very securely.

One often learns most from a failure, and my failure to obtain primary union of the wound in the bladder has taught me how well a few strands of

catgut, carried to the bottom of the wound, will direct the urine through the lower part of the wound in the soft parts. Such a drain will, therefore, serve the double purpose of draining the wound and of preventing extravasation of urine in the event of primary union not being obtained. The boy might have been up on the 6th day without retarding the healing of the superficial wound; but as I was more anxious for a good result than for a good record, I preferred to keep him secure in bed. I would not attempt to draw off the water in future after operation, but allow the patient to pass it voluntarily which was the case from the first with my little patient.

Dr. TILSTON said that he did not think the mortality of the lateral operation so great as Dr. Gibson had put it. In Heath's Dictionary of Surgery it was given at 13·4 per cent. Again, he did not believe at all that emasculation followed the lateral wound. In India, where so many hundreds of lateral operations were done every year, the cases could be followed out, and he felt sure that such a result would have attracted the notice of both patients and surgeons, had it occurred with any frequency.

Dr. LITTLE felt much obliged to Dr. Gibson for his very interesting paper. It was an important fact that a great and old-established operation had been threatened. Moreover, the choice of operation now gave surgeons greater powers. It was a good thing to know that the high operation was so safe as Dr. Gibson had made it out to be. He did not consider the case of sterility following the lateral operation as made out. The undeveloped state of the parts in children would perhaps cause any injury done to be of less importance. There were more children operated on than adults, and he felt sure that if sterility did follow, surgeons would be oftener consulted as to the cause. He considered that sterility from division of the seminal ducts implied subsequent atrophy of one or both testicles, and this would direct the attention of the patient and surgeon to the cause. He was especially obliged to Dr. Gibson for the honest manner in which he had told his points of failure—he believed that, especially in a new operation like this, more was often learnt from one failure than from a dozen successes.

Dr. TAYLOR had never performed the operation nor seen it performed. He used to wonder why the high operation was not more attempted, for the lateral operation was a severe one, and the supra pubic anatomically easy. He believed that it would soon become an established operation. He remembered seeing Sir Wm. Ferguson making a V-shaped incision through the whole breadth of the prostate with a gorget in the case of a large stone, and he wondered how the ejaculatory ducts could escape being divided.

Dr. BANCROFT said that after lateral lithotomy one occasionally observed fistulous closing of the wound, with incontinence, as a result. Occasionally too, stricture was a result of the urethral incision. He remembered a case of the kind which had been very difficult to treat. Late he had operated on an old patient by the lateral method and had obtained primary union—no water having passed by the perineal wound.

Dr. LOVE thanked Dr. Gibson for his interesting paper. He had been present at the operation, and it struck him that had the meatus been incised a No. 7 lithotrite could have been introduced. The results of lithotrity on children, as recently recorded by Dr.

Keegan, were so encouraging, that he would be inclined under ordinary circumstances to prefer the crushing to either of the cutting operations. In adults, of course, there would be no hesitation. Dr. Gibson's had been a most instructive case to him. In suturing the bladder he would, of course, not include the mucous membrane, and would be specially careful about the angles of the wound. Sir Wm. MacCormac, in his recent paper on suture of the bladder for traumatic rupture, gives a diagram showing how he had inserted his stitches even beyond the angles of the wound to prevent leakage. As to emasculation, he had had a patient in whom lithotomy by the lateral method had been performed 16 years ago in the Birmingham General Infirmary. The man was then 31 years of age, and had had three children previously but none since. His wife had enjoyed as good health after as before the operation. Emasculation, he believed, often followed the lateral operation. As to rapidity of healing, if primary union were obtained, of course the high operation was the best—*vide* case recorded from Great Ormond Street Hospital, in which the child was up and well in a week.

THE MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

A MEETING of the Medical Section of the Royal Society was held in the Society's Rooms, Sydney, on May 20, 1887.

Present :—Drs. Sydney Jones (in the chair), MacCormick, Fairfax Ross, Chambers, Crago, Knaggs, Chisholm, Jenkins, Eichler, Graham, Skirving, O'Riley, Worrall, Wilkinson, Bowker, Roth, McCulloch, Goode, Fiaschi, Maher, and Hoff.

Dr. Sydney Jones thanked the members for having elected him president, and suggested that some evenings should be devoted to the consideration of such rare and interesting diseases, as *e.g.*, "myxodæma," "peripheral neuritis," &c., &c.

The minutes of last meeting having been read, Dr. Crago read a paper on a case of child with "coloboma of iris of the right eye," and absence of eyeball on left side. The child also had "imperforate anus, and recto-vaginal fistula. Child exhibited.

Dr. Graham then read his paper on a case of "haemophilia" (see page 245), and gave an historical sketch of the disease, and exhibited two patients—brothers. An interesting discussion followed, in which Drs. Crago, Eichler, Chisholm, Fiaschi, Wilkinson, Worrall, Jenkins, and Skirving took part.

Dr. Sydney Jones then read a paper on a peculiar case of the so-called "post-hemiplegic chorea." Patient exhibited.

Dr. Roth exhibited a specimen of "two kidneys with bladder and enlarged prostate," from a patient who had had retention of urine. The bladder had been punctured through rectum, one kidney was cystic and both ureters were enlarged. Dr. Chisholm made some remarks as to treatment of prostatic cases.

The meeting terminated at 10.15.

An ordinary general meeting of the Medical Section of the Royal Society was held in the Society's Rooms on June 17, at 8 p.m.

Dr. Sydney Jones, president, in the chair. A large number of the members of the profession were present, and amongst them Drs. Worrall, Wilkinson, Bowker, Faithfull, Chambers, Fairfax Ross, Knaggs, Quaife, Anderson Stuart, Goode, Crago, Cox, Munro, Chisholm, Skirving, Graham, Hoff, Marshall, Milford, Roth, Garrett, Fiaschi, Blaxland, Twynam, Muskett, Mac-

Laurin, Jeukins, MacCormick, Kendall, Eichler, Ellis, Foreman, &c., &c.

The minutes of the previous meeting having been confirmed, Dr. Fairfax Ross read a paper on "peripheral neuritis due to alcohol," and quoted two cases.

Dr. Sydney Jones gave his experience of the cases of so-called "alcoholic paralysis," and of "peripheral neuritis following diphtheria, gout, and lead poisoning." Professor Anderson Stuart, Drs. Ellis, Hoff, Skirving, Kendall, and Wilkinson joined in the discussion.

Dr. MacCormick showed a specimen of scapula with sarcomatous growth removed by him, also photographs of the patient after recovery, showing the lines of incision very clearly. The photographs were taken by Dr. Knaggs.

The meeting terminated at 9.20.

MEETING OF SYMPATHY WITH DR. WRIGHT.

A LARGELY-ATTENDED meeting of members of the medical profession of Sydney and suburbs was held in the hall of the Royal Society, Elizabeth-street, Sydney, on June 17, for the purpose of expressing sympathy with Dr. H. G. A. Wright for the painful but false situation in which he was lately placed as the defendant in a criminal action instigated by certain unprincipled persons. Dr. P. Sydney Jones occupied the chair, and amongst the gentlemen present were :—The Honorable J. M. Creed, M.L.C., Professor Anderson Stuart, Drs. MacLaurin, Tarrant, Knaggs, Chambers, Milford, Scott-Skirving, Goode, Steel, Fiaschi, Watson Munro, Marano, Quaife, Ellis, Fairfax Ross, Chisholm, Norrie, Leyden, Laure, T. B. Clune, Garrett, and others.

The CHAIRMAN said they had met together for the consideration of an address to Dr. Wright, who, through the proceedings he had taken in connection with the conspiracy against him, had earned the thanks of the whole of the medical profession. A weaker man and even a strong man might have done anything to avoid such a catastrophe, and no doubt hundreds of persons had submitted to similar vile and atrocious extortions. The address embodied three things—viz., their sympathy with Dr. Wright in his late unfortunate position ; their congratulations upon his having triumphantly established his character ; and their gratitude to him for having rid the community of three unprincipled scoundrels. It was proposed to present Dr. Wright with a purse of sovereigns to meet the legal claims, and he (the chairman) was pleased to announce that the appeal had been so well taken up.

Dr. GARRETT announced that he had received over 200 letters from all parts of the country and 105 subscriptions, amounting to £125. (Applause.)

Dr. GOODE moved :—

"That an address be presented to Dr. Wright, expressing the sympathy of the medical profession as a body."

Dr. CHISHOLM seconded the resolution, and in doing so said that he was impressed with the importance of the movement, not only in so far as it concerned Dr. Wright personally, but every member of the medical profession in New South Wales. Their united thanks were due to him for his prompt action, and the successful issue of the prosecution. Their profession had cause for thankfulness that the punishment meted out to the miscreants who had tried to impose upon Dr. Wright was such as to effectually deter others from following their example. (Applause.) From the very nature of their calling, medical men were brought into relation so intimate with all classes of people as to leave them exposed to charges of the gravest character.

made by unscrupulous and designing persons; and in view of that consequence, it was highly desirable that they should take steps to safe-guard themselves. The sympathies of the members of the medical profession were necessarily with the sick and the suffering, and it was necessarily revolting to their natures to attempt to betray the trust which was reposed in them by their patients. Dr. Wright enjoyed the fullest sympathy and confidence of the members of the profession in this colony, but that was not sufficient; and it was incumbent upon them to give that feeling practical shape.

The resolution was carried unanimously.

Professor ANDERSON STUART moved, and Dr. SCOTT-SKIRVING seconded, the adoption of the following address:—

"We, the undersigned members of the medical profession practising in New South Wales, have been deeply impressed with the painful position in which you have lately been placed by the acts of unprincipled and designing persons. We felt sure from our knowledge of your character, based upon many years' experience of your general and professional conduct, that the charge brought against you was false and malicious, and we heartily congratulate you upon having triumphantly defeated it. Under very trying circumstances you have acted in a most honourable, courageous and unselfish manner, and we hereby tender you the thanks of the profession for having rid society of an unscrupulous trio and your brethren of an ever-threatening danger. We assure you of our sincere sympathy, and we trust that you may remain many years among us as a friend and an example of what a professional man should be."

Professor Dr. STUART said, it seemed to him that in the framing of the address which he had just read, and the adoption of which he had moved, the committee had very wisely considered that they ought to make it as comprehensive as possible, so as to meet the many-sidedness of the position. It dealt with the matter so as to let them speak as citizens, as practitioners of medicine, and as men. It expressed their detestation, as citizens, of the foul crime of conspiracy, which, if it ever became prevalent, would as surely sap the foundations of society and destroy the State, as its absence secured them against the malevolence of individuals, and the oppression of numbers or of the powerful and bad. The law as it stood, therefore, meted out heavy penalties to convicted conspirators. This had been the fate of the trio whose concerted wickedness had brought trouble on the head of their fellow-citizen, and well had they earned their reward. As medical practitioners they thanked their brother for his fortitude in braving what another might have shrunk from, since, however successful a resistance in such cases promised to be, an appeal to the law was always repugnant to the feelings and distracting to the mind. Further, the verdict was not always an expression of the truth; miscarriages of justice do and must happen from time to time, and short of that, proof was not always so easy that the legal certainty of the crime was as great as the moral conviction of it. Thus, there was always a certain risk of defeat. And what did that mean to the medical man in practice? Nay, rather, what did it not mean? It meant well-nigh everything. When they considered the delicate and difficult relations into which he was daily brought; when they considered what confidence must, from the very nature of the circumstances, subsist between the physician and his patient; then they could appreciate what a value the public rightly placed on his integrity and honour. Again, when they considered how open he was to the

attacks of bad men and bad women, they saw how liable he was to the peril of utter ruin, social and material. With these risks attending them—every one of them—and with the knowledge that such occurrences as that which had so recently been brought to light were not by any means so rare as the public might imagine, should they not hasten to hold up their brother's hands, and might they not look to the force of an enlightened public opinion to hold up their own? Lastly, as men, they were to express their sympathy with their fellow-man in his affliction. It would not be kind to dwell on the terrible visitation which had come upon him. Those who had the privilege of his friendship would know whom he had lost, and how dear they were to him; but they ventured to assure him of their confidence, their respect, and their high esteem, and to ask him to give them still his friendship through the many years during which they trusted they would work together for the comfort of the poor, the consolation of the miserable, and the relief of suffering humanity. (Applause.)

Dr. SCOTT-SKIRVING seconded the resolution, and in doing so pointed out that the lesson to be learnt from the case of Dr. Wright was that they should bear one another's burdens. It convinced him of the necessity for establishing a Medical Defence Association. The project had already been set in motion by certain energetic persons, and he hoped that it would not be allowed to languish.

The resolution was carried by acclamation.

Dr. TARRANT moved the following resolution:—"That a subscription list be opened to present Dr. Wright with a suitable address and a testimonial on this occasion." Dr. Tarrant said that it was the duty of every one of them, when the conduct of one of their profession was wantonly assailed, to come forward and show to the public, by their action, that they were determined to stand by one another. Dr. Wright had lived amongst them for many years, and they had learned to look upon him as one of the leading practitioners of this city—a man whose conduct was above suspicion.

A great deal of discussion took place as to the form which the testimonial to Dr. Wright should take. It was eventually resolved, on the motion of Dr. Quaife, seconded by Professor Stuart,—"That an illuminated address be presented to Dr. Wright, and a purse of sovereigns given to him as a money testimonial."

MEETING RE CLUB PRACTICE.

A GENERAL Meeting of the Medical Profession of Sydney and Suburbs, was held in the Royal Society's House, Sydney, on Friday evening, 24th June. Dr. MacLaurin occupied the chair, and there were about 30 gentlemen present. Dr. Ellis, the Honorary Secretary of the Committee appointed to deal with this subject, read a draft memorandum of agreement, which was then discussed, clause by clause, and a large number of amendments were moved. The principal discussion arose upon the clause fixing the minimum price for accepting lodges, as also the one for making it necessary for lodge patients to give notice with regard to accouchement cases to the Secretary of the lodges. The memorandum as amended was ultimately agreed to. A committee was then formed to initiate the Medical Defence Association which was decided upon at a previous meeting. A hearty vote of thanks was accorded to Dr. MacLaurin and Dr. Clubbe for their action in this matter.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which is found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JULY 15, 1887.

EDITORIALS.

LIMITED QUARANTINE V. MEDICAL INSPECTION.

It is not very long since the London *Lancet** took advantage of the outbreak of cholera on board the "Dorunda" to condemn in forcible terms the Quarantine which was imposed upon that vessel. Our contemporary, promulgating the English dogma of medical inspection, compared our Australasian method to the unscientific practice followed by the heathen Turk; and we ventured, as our readers will remember, to condemn the custom of attempting to thrust down other people's throats a course of action which the English adopt mainly because their circumstances constrain them.† Notwithstanding the *ex cathedra* tone of the article referred to, we have expected some comment upon the recent serious outbreak on board the mail steamer "Preussen;" for it must surely appear to our contemporary a remarkable circumstance that this vessel, which arrived at Adelaide after losing a passenger by small-pox, should have been so effectually dealt with by Quarantine that not a single case of the disease occurred among the shore population. The "Preussen" touched Australia December 15, 1886, with 694 persons on board. She landed 27 passengers and 2 stewards at Adelaide, 280 at Melbourne, and at Sydney 812 plus a crew numbering 123; and among these parties respectively there broke out, 5 or 6 cases, 29 cases, 64 cases, and 15 cases of small-pox, several of which ended in death. There was no communication of disease at Quarantine from persons there falling sick to others there confined. After an interval from the occurrence of the last case which did not exceed 21 days, those who had escaped attack were released; and they were set at liberty among populations which in

no instance can be said to be well-vaccinated, and at Sydney are better described as unvaccinated. Now, under medical inspection, 112 of these cases of small-pox would have been scattered among the partially-protected populations referred to; for only one case of sickness among the 694 existed when the "Preussen" reached Sydney, her port of destination. Or, if the processes of cleansing which medical inspection prescribes should have occupied two or three days, yet at the end of that time but nine more sick would have been found; and the rest, of whom more than 100, although in apparent good health, were really incubating small-pox, would have been discharged. But had this course been pursued it cannot be doubted that there would have been at least some communication of disease to the shore population, and, in all probability, a very wide-spread epidemic would have arisen. South Australia, Victoria, New South Wales and Queensland would all have suffered, for those who fell ill were bound for all these colonies.

In the *Lancet* for May 14 is a long editorial item on this subject, which, while it is incorrect as to several matters of fact, is not quite perspicuous. Its gist, however, appears to lie in the following sentence:—"Experience in Europe has shown, whatever the disease to be dealt with may be, that true preventive measures are far more neglected in countries resorting to quarantine than in those who (sic) do not enforce it, and the extent of neglect may often be largely measured by the tenacity with which the quarantining of sick and healthy alike is maintained." The analogy here drawn cannot be accepted. Comparisons between Europe and other parts of the world have fascination for the Englishman, who too often seems never to have passed the limits of his own tight little island; but they must not be pushed too far where historical and physical considerations are involved, on pain of confusion. In fact Quarantine is not here relied upon to the neglect of true preventive measures. The case is perfectly simple. To speak, for convenience, only of the four colonies already mentioned, in two of them vaccination is compulsory; in two it is voluntary and gratuitous, but practically neglected by the people. In season and out of season the Health Authorities of the unprotected parts, and this journal, are instant in urging the importance of compulsory vaccination; but the people will have none of it. Now, notwithstanding these four colonies cover an immense area, intercommunication is so easy, so rapid, and so clearly a condition of their development, that from the standpoint at present taken up they must be regarded as one country; and, since size is relative to means of travel, as no large country either. Under these

* *Lancet*, May 5, 1886.
† *Gazette*, August 15, 1886.

circumstances the Health Authorities have agreed that **THEY CANNOT AFFORD TO REFER THE OBSERVATION OF SUSPECTS TO THE COUNTRY AT LARGE.** In practice, isolation is not the best safeguard against small-pox ; but, then, half-a-loaf is better than no bread. The case is similar with cholera. It is enough to say that to furnish all the larger towns of Australasia with pure water and good sewers must of necessity occupy many years. Quarantine, as here understood, is primarily a detective measure, not a preventive measure; so also is medical inspection. But the former is thorough as far as it goes, while the latter is less far-reaching, and is only superficial at the best.

It almost seems as though medical inspection had begun to assume in the English mind some of the attributes of a fetish. At all events it is clear that the *Lancet*, although enjoying the amplest opportunities, has failed to seize the mode and aims of such Quarantine as is practised here, and, as far as possible, in the United States. We therefore recommend for consideration that definition of it which was proposed by the Special Delegate of New South Wales (Dr. Ashburton Thompson) at the Australasian Sanitary Conference of Sydney, 1884. It runs as follows ; and the action defined, being taken only in the case of vessels known to be infected, is called Limited Quarantine :—“The examination conducted to ascertain the presence or absence of the causes of infectious disease, without detention for more time than may be necessary for the discovery and the removal or destruction of such causes.”

PUBLIC VACCINATORS IN NEW ZEALAND.

A DEPUTATION from the New Zealand Medical Association, during a conference which was held at Wellington in May last, waited on the Premier for the purpose of obtaining his assistance towards getting a measure passed which would prevent vaccination being performed by other than qualified medical men. Sir Robert Stout promised his aid in the matter.

This proposition will, doubtless, be thought by unthinking laymen to savour of that selfishness which they are so apt to attribute to medical men. A little thought, however, would demonstrate that the proposition is made in the true interests of the public. No one having the requisite knowledge, who has studied the question without prejudice, can refuse to believe that the discovery

of the protective power of cow-pox has been the means of saving innumerable lives, and that any proceeding which tends to bring the operation into disrepute is a public calamity. The evils, rare as they are, which have been very occasionally proved to have arisen as a consequence of vaccination, must have arisen from its performance by either careless or ignorant persons on subjects whose health rendered them at the time unsuitable. To render these instances as unfrequent as possible, it is advisable that only men who from their professional knowledge would know when the person desiring to be vaccinated was in fitting health should be allowed to perform it, and such men would, from their position, be less likely to be careless than men who, perhaps, have had no other training than the witnessing of the operation a few times by a public vaccinator. In New Zealand there are many such persons who hold appointments under the Government of that Colony as public vaccinators.

EPIDEMIC OF TYPHOID FEVER AT KIAMA.

UPON report of the Government Medical Officer for the Kiama District, and by request of the Mayor of Kiama, the Chief Medical Inspector of the Board of Health (Dr. Ashburton Thompson) recently visited that town to make enquiry into the circumstances under which an epidemic of typhoid occurred there. From his official report it appears that during two months, reckoned from the middle of April, about 60 cases occurred, the outbreak having apparently ceased at the date of enquiry. The disease has been seen there, but to a less extent, in former years, and nothing especial was discovered to account for the present outbreak. But the general state of the town was found extremely dirty ; there has never been any systematic scavenging, either of night-soil or garbage ; gutters in the main streets are improperly constructed, and imperfectly graded ; cesspits are universal, and the older houses are reputed to have two or three attached to them, old ones having not been emptied but covered over, and the house removed to a new hole dug adjacent to that relinquished. When it is learned that the water-supply for food purposes is largely drawn from underground sources—that is, either from surface wells, or underground tanks which are not more perfectly constructed than usual—the cause of the epidemic scarcely requires further elucidation. Dr. Thompson points out that the conditions described are precisely those under which several of the zymotic diseases are fostered and

disseminated, and that in this country, and for the present, typhoid is the zymotic most certainly developed under them. No doubt, at some future time, we shall find that they are equally favourable to the spread of cholera and yellow fever. In the meantime, it is observed, all three diseases fall within the class distinguished by the epithet "preventable." This they enjoy *par excellence*, just because the conditions which are indispensable to their propagation are very easily abolished. And when the water supplied to any population is polluted with excrementitious matter, its contamination with the specific poison of typhoid is only a matter of time. As soon as a few cases have been imported to an unscavenged district, and a few areas have thus been polluted, other cases begin to show themselves; then, sooner or later, favourable seasonal conditions supervene, and a widespread epidemic ensues. It is also very properly pointed out that although under certain circumstances the air may be so polluted that this disease is taken by inhalation, everywhere it is seen that, practically, the spread of typhoid is intimately bound up with specific foulness of drinking water; and, conversely, that populations supplied with pure drinking water practically enjoy immunity from it. These remarks apply with especial accuracy to country towns which are unprovided with sewers.

From paragraphs in the local prints, it appears that the inhabitants feel sore at being told that their affliction is due, not to unavoidable misfortune, but to their own wilful neglect. From any sanitary standpoint, Kiama appears to be, in point of fact, not so much a town as a camp; or, at best, as a haphazard collection of dwellings. Before it can attain to the title of "The Brighton of the South," to which some of its inhabitants aspire for it, a very great deal of quite commonplace, humble work, must be done. Brighton, England, is a city whose rate of mortality never places her lower than third in the list of 28 large towns of England arranged inversely as their death-rate; and she enjoys this position, not by natural advantage, but in virtue of very careful sanitary organisation. As far as we can judge, the municipal arrangements of Kiama seem, at present, to be such that a gang of three or four men with brooms and carts might, under intelligent direction, effect a remarkable change for the better in the appearance and healthiness of the town. It will be time enough when the unostentatious but valuable results of what is popularly known as "elbow grease" have been attained to begin to speak of magnificent and costly schemes of sewerage and house-to-house water supply. At present these are impossible, since the Corporation is without funds.

INTERCOLONIAL MEDICAL CONGRESS,

Adelaide, Aug.-Sept., 1887.

President—J. C. VERCRO, M.D., F.R.C.S.; *Chairman of Reception Committee*—E. C. STIRLING, M.D., F.R.C.S.; *Secretary of Reception Committee*—MELVILLE JAY, L.R.C.P., &c., &c.

THIS Congress will meet at the University, Adelaide, on Tuesday, August 30, and sit each day until Friday, September 2nd.

His Excellency Sir W. C. F. Robinson, Governor of South Australia, one of the Patrons, has promised to attend the inaugural meeting, which will be opened by the President's address. The Chairmen of the sections—*State Medicine* (Dr. Whittell, Adelaide); *Medicine* (Dr. J. Williams, Melbourne); *Surgery* (Mr. T. N. Fitzgerald, Melbourne); and *Gynaecology* (Mr. Foreman, Sydney), will deliver leading addresses in their respective departments on the succeeding days, when sectional meetings will also be held. Leading practitioners from the various colonies and others have expressed their intention of attending; some of them deputed to represent associations and institutions.

The proceedings of the congress, with the papers read, will be published. Members will each receive a copy of such transactions. The meetings in the section *State Medicine* will be open to Fellows of Royal and other kindred societies.

It is desirable that intending members should, without delay, register their names, that they may receive cards of membership and papers entitling them to claim the special reductions in fares granted by all the railway departments (half-fares on producing certificates of membership), and intimate to the secretary the names of accompanying friends, that invitations may be sent for the various entertainments. The Chief Justice gives a conversazione on Tuesday night, the Mayor an official reception and luncheon. The Governor has expressed his intention of being at home to members of the congress and their friends on the evening of Thursday, September 1, and there are other engagements of a social nature being arranged. South Australian members will invite the visitors to dine with them on the closing evening. The Literary Committee will be materially assisted in their work by the early transmission of papers proposed to be read. All legally qualified medical practitioners are eligible for membership on subscribing the sum of one guinea. Provision will be made for the exhibition of pathological and other specimens.

Communications may be sent to Dr. Poulton, Hon. Sec., Adelaide.

LETTERS TO THE EDITOR.

THE GENERAL COUNCIL OF MEDICAL EDUCATION AND THE MELBOURNE MEDICAL SCHOOL.

(To the Editor *Australasian Medical Gazette*.)

SIR,—Will you be kind enough to insert the enclosed letter in your next issue, as it has an important bearing upon the matter referred to in your April number of the *Gazette* of this year? A tribunal, such as the General Medical Council of Great Britain is, will be better qualified to decide as to whether the curriculum of the University of Melbourne is fit to be registered as up to the standard, than the gentlemen who formulated that curriculum, and who have lately averred that "it (the curriculum) was now recognised by the said council," which it has not been up to date, as is apparent from the subjoined letter just received.

I am Sir,

Very faithfully yours,

F. W. ELSNER, F.R.C.S.I.
Richmond (Melbourne), July 2, 1887.

No. 2816.

General Council of Medical Education and Registration
of the United Kingdom,
299 Oxford Street, London, W.
May 26, 1887.

SIR,—In answer to your letter of March 28, 1887, I am directed to inform you that your former communication was forwarded, by direction of this Council, to the University of Melbourne, on December 6, 1886, and that the Council have no knowledge of anything which has since occurred on the subject.

I am, sir,

Your obedient Servant,

W. J. C. MILLER,
F. W. Elsner, Esq.
Registrar.

CLUB PRACTICE.

(To the Editor of the *A. M. Gazette*.)

SIR,—I was much disappointed on receiving the June number of the *A. M. G.* to find that the subject of Club Practice had entirely dropped out.

I trust the matter will receive further and earnest attention, so that, ere long, some united action may be taken to regain and retain the prestige we are fast losing in having our profession dragged to the level of a petty trading concern. I cannot now attempt to suggest any "plan of campaign," but trust some one with greater experience may be induced to do so. The great difficulty ahead will be to control the greed of those batches of new arrivals whose numbers are, unfortunately, becoming far too great.

As a rule, these men are ready to snatch any offer made, regardless of the indignity they are bringing on their newly-acquired profession. If the tide of medical emigration continues to set towards Australia, and the country is to be overrun with doctors, we shall not have long to wait for a more deplorable state of things than we have to contend with even now. At the present time the supply is far in excess of the demand, and every week the number is increased.

I am, Sir, &c.,

MEDICUS.

A CORRECTION.

(To the Editor of the *A.M.G.*)

SIR,—I observe in the *Australasian Medical Gazette* of June 15, you notify that I have commenced practice at Warracknabeal. This is an error. I have not started practice there, nor have I any such intention.

I am, yours faithfully,

WM. MOIR.

Corack, Victoria, June 18, 1887.

THE MONTH.

NEW SOUTH WALES.

IN the Legislative Assembly, on June 24, Sir Henry Parkes, in reply to Mr. Ross, said he would give his assurance to the hon. member and to the House that the Government would seriously consider whether they could possibly introduce next session a Medical Bill for the better protection of the public from being imposed upon by unregistered and unduly qualified practitioners or quacks; also, to prevent certificates of death from such being accepted as evidence of death and registration.

THE Minister for Mines (Mr. Abigail) has received two samples of mineral water from a spring near Dubbo. It is Mr. Abigail's intention to have the water, which is said to possess curative properties of a high order for certain diseases, such as rheumatism, analysed by an expert, with a view to its qualities being distinctly ascertained.

AT the meeting of the Senate of the Sydney University, held on June 27, a report was received from the faculty of medicine, containing the following resolution, which had been passed at a special meeting of the faculty, held on Thursday, June 2:—"That considering the intimate connection which has existed from the earliest times in all properly-constituted universities between the study of medicine and that of the other subjects which are taught in universities, the faculty of medicine earnestly requests that the senate will not sanction any step which would separate the faculty of medicine, financially or otherwise, from the University, of which it is an integral part. They make this request after carefully considering the recent address of the Chancellor, in which such a suggestion has been made." The Dean of the Faculty of Medicine gave notice of the following motion:—"That the senate, recognising the status of the faculty of medicine as an integral portion of the University, has no intention of allowing the study of medicine to be in any way dissociated from the influence of the University."

AT a recent meeting of the Directors of the Sydney Hospital, a letter was received from H. Shields, the City Coroner, notifying that by direction of the Minister for Justice, in future no fees would be allowed to any salaried medical officer of any public hospital for making *post-mortem* examinations or giving evidence in connection with the City Coroner's Court. It was decided that Messrs. Senior and Josephson should wait upon the Minister, pointing out that all fees received by the resident medical officers were paid into the hospital funds, and that they received as an equivalent for such fees a sum of £50 a year from the funds.

A SEAFARING man, who was a passenger on board the steamship "Port Victor," which reached Port Jackson from Singapore on June 20, presented himself

as an in-patient at one of the Sydney hospitals on July 1, when he was found suffering from small-pox ; he was at once conveyed to the "Faraway," the floating hospital at the Quarantine Grounds.

In a recent issue of the *A. M. Gazette*, we published an advertisement of Mr. Berkeley Hill, F.R.C.S., senior surgeon to University College Hospital, London, together with an editorial note, stating that it was proposed to rebuild University College Hospital at a cost of £50,000, and that the building would be commenced when £30,000 had been promised. Consequently a meeting of former students of University College was held at the Oxford Hotel, Sydney, on June 14, Dr. P. Sydney Jones in the chair. After a conversational discussion a subscription list was initiated, the sum of £141 being promised amongst those in the room. It was also resolved that steps be at once taken to hold a banquet on the same date as the one held by the old students of the college in London.

The foundation-stone of the new Cottage Hospital at North Shore (Sydney) was laid by Sir Henry Parkes on June 18.

At a recent meeting of the directors of the Wagga Wagga Hospital, it was decided to so alter the rules as to admit of the employment of a paid medical staff, and Dr. Hillas, who had acted as honorary medical officer for many years, was awarded £100 as token of recognition of his past services, and was appointed to the new paid position at a salary of £100 per year. Dr. Hillas will work in conjunction with Dr. Tayler, who was unanimously elected honorary medical officer of the institution.

At a meeting of the Board of Directors of the Sydney Hospital, held on June 7, a letter was received from Dr. R. Westrum resigning his position as resident medical officer in the institution, as he was about to go into private practice. Several members spoke in the highest terms of the services rendered by Dr. Westrum during the past three years, at the same time expressing regret that they were about to lose his services. On the motion of Mr. M. Chapman, M.P., it was decided to accept the resignation, to tender a cordial vote of thanks to Dr. Westrum, to furnish him with a certificate testifying to the esteem in which he was held, and to wish him every success in his new sphere.

At an inquest concluded on June 27, on the body of a young child which died at Waterloo, near Sydney, on June 17, under peculiar circumstances, after taking medicine supplied by "Dr." Pitt, one of the numerous unregistered practitioners in Sydney, the jury, after a brief deliberation, returned a verdict of manslaughter against Pitt, who was committed for trial at the Central Criminal Court.

MILES EGAN, M.R.C.S. Eng., 1850, of Sydney, died at Karori, Wellington, N.Z., on June 8; the deceased gentleman was formerly police surgeon and medical superintendent of the N. S. Wales Vaccination Institute for a number of years.

LAURENCE JOHN HALKET, L.R.C.P. Lond., 1870, late of Quirindi, and formerly in practice in Wynyard-square, Sydney, died on April 17 last, on board the ship "General Roberts," on her voyage from Sydney to London; the deceased gentleman was at one time Resident Surgeon at the Sydney Infirmary.

DR. W. C. ASKE, of Newcastle, has removed to Kiama.

DR. G. P. BALDWIN, late of Murrumburrah, has commenced practice at Neutral Bay (North Shore), a suburb of Sydney.

DR. N. E. BOYD has returned to Sydney from his trip to America and England, and resumed practice at 53 Castlereagh-street.

DR. LOFTUS CAMPBELL has commenced practice at Clarence Town, a seaport town on the Williams River, 114 miles N. of Sydney.

DR. J. C. L. COLPE, of Nyngan, has removed to Nymagee.

DR. M. L. A. C. D'ENGLESQUEVILLE, M.D. Paris, late surgeon on board the M.M. str. "Dupleix," trading between Sydney and Noumea, has commenced practice at Hunter's Hill, a favourite suburb of Sydney.

DR. H. P. C. GORRICK has commenced practice at Tamworth.

DR. J. P. KEALY, of Gulgong, has removed to Inverell.

DR. JAS. MACKY has commenced practice at Blayney, 166 miles W. of Sydney.

DR. J. P. MCNEILL has commenced practice at Burwood, a suburb of Sydney.

DR. H. M. MADDEN, who left Moss Vale for Franklin (Tas.) in April last year, has returned to Moss Vale, and resumed practice.

DR. R. WESTRUM, for the last three years one of the resident medical officers at the Sydney Hospital, has succeeded to the practice of Dr. Colpe, at Nyngan.

DR. EDWD. YEATES has succeeded to the practice of Dr. Thos. Lane, at Warialda; Dr. Lane has removed to Inverell.

NEW ZEALAND.

DR. W. E. HAON, the able Resident Physician Superintendent of the Sunnyside Hospital for the Insane, Christchurch, for the last seven years, has resigned this position, and entered into private practice at "Freshford House," Lichfield-street E., Christchurch.

THE St. John Ambulance Association in Christchurch has undertaken the registration of professional nurses, which step will doubtless prove of considerable public service, and which has been heartily approved of by the medical staff.

DR. HY. O'BRIEN DECK, late resident medical Officer at the Melbourne Hospital, has commenced practice at Motueka, 32 miles W. of Nelson.

DR. W. A. HARRISON, late of Lyttelton, has commenced practice at Dunedin, in conjunction with Dr. R. Martin.

DR. W. L. CHRISTIE has commenced practice at Outram (Otago), Dr. C. B. Innes at Wellington, Dr. W. J. Mackie at Nelson, and Dr. H. C. Parsons at Kaiapoi (Canterbury).

DR. R. C. EARLE has resigned his appointment of Surgeon to the Wangani Rifle Volunteers.

QUEENSLAND.

A HOSPITAL has been established at Thargomindah, in a grazing district, 670 miles W. of Brisbane.

SOUTH AUSTRALIA.

MR. HUGH FERGUSON, M.R.C.S. Eng., L. et L. Mid. R.C.P. Edin., 1866, J.P., honorary surgeon of the S. A. Institution for the Blind, Deaf, and Dumb, was found dead in his consulting room at Glenelg on June 25. An ordinary measuring glass, which had contained hydrocyanic acid, was found on the table alongside.

DR. B. P. MORISON, late of Glenelg, has removed to Grace, 40 miles N. of Adelaide.

TASMANIA.

A TASMANIAN Branch of the British Medical Association has been established at Hobart. Dr. T. C. Smart has been elected president, and Drs. Parkinson and Wolfhagen secretaries; a provisional committee has also been appointed, consisting of Drs. Butler, E. L. Crowther, Elliott, Giblin, Gray, Payne, and Perkins.

FOUR nurses in the Hobart General Hospital have been attacked with typhoid fever.

DR. AGNEW, of Hobart, has resigned his seat in the Tasmanian Legislative Council.

VICTORIA.

AT a meeting of the hon. medical staff of the Alfred Hospital, held on June 13, it was resolved that it was desirable to establish a gynaecological department in connection with the hospital. The committee of managers have agreed to forward the views of the medical staff as much as possible.

THE adjourned inquest on the body of Mrs. Jane Beedham, late licensee of the Waterloo Hotel, Melbourne, who died under circumstances pointing to an illegal operation having been performed, was concluded on June 14. Mr. C. A. Smyth, who appeared for the Crown, tried to implicate Dr. Burke and Sergeant Corbett of negligence in connection with the death of deceased. The coroner, however, exonerated Dr. Burke from all blame, except that, in a moment of good nature, in order to avoid a family scandal, he omitted to mention all the circumstances of the case in the death certificate. It was evident that the deceased had been operated on before Dr. Burke was called; and with regard to Sergeant Corbett he did not think any jury would sustain a charge of culpable negligence. The jury returned a verdict that the deceased died from the effects of abortion criminally procured by a person or persons unknown, and that such person or persons were guilty of wilful murder.

FROM the 1st January last, to June 12, 1,704 cases of typhoid fever were reported to the Central Board of Health of Victoria, of which 386 have proved fatal.

AN indignation meeting was held at Donald, on June 8, when the following motion was carried : "That this meeting considers the report of Dr. A. Shields, regarding the sanitary condition of Donald, inaccurate in parts, exaggerated, and couched in misleading language."

THE services of Dr. A. S. Joske, of the Alfred Hospital, in connection with the Typhoid Camp, closed on May 26, have been brought under the notice of the Government by the Central Board of Health, with the view of presenting him with an honorarium as a mark of appreciation of his zeal and ability.

DR. J. COANE, late of Hamilton, has commenced practice at "Wattle Lodge," Bay-street, North Brighton, a suburb 8 miles from Melbourne.

DR. H. H. FLEMING, late resident medical officer at the Pleasant Creek District Hospital, Stawell, has commenced practice at Donald, in an agricultural district, 183 miles N.W. of Melbourne.

DR. A. S. JOSKE, of the Alfred Hospital, Melbourne, has been the recipient of a valuable gold lever watch, bearing the following inscription on the back :—"Presented by the Central Board of Health, with approval of the hon. the Acting Chief Secretary, to Alexander Sydney Joske, M.B. and Ch.B., in recognition of his attention to typhoid fever patients. Melbourne, February to May, 1887."

DR. ALFRED KEENAN, late house surgeon and house physician at St. Vincent's Hospital, Sydney, has commenced practice at "Elmslie," Wellington-street, Windsor, a suburb of Melbourne.

DR. J. H. MACKENZIE, late of Bega (N.S.W.), has commenced practice at Tallangatta, 215 miles N.E. of Melbourne.

DR. JOHN MCNAUGHTON, a new arrival, has commenced practice at Hamilton, an important inland town, 224 miles W. of Melbourne.

DR. EDWARD E. ROSENBLUM, has been appointed a junior deputy medical superintendent, Hospitals for the Insane in Victoria, for six months, on probation.

DR. G. A. SYME, Demonstrator of Anatomy at the Melbourne University, has commenced practice at 34 Russell-street.

DR. ALEX. STEVEN, late of Bordertown (S.A.), has commenced practice at Collingwood, a suburban city, adjoining to Melbourne.

MR. JOSEPH TAYLOR, L.S.A. Lond., 1828, formerly medical superintendent of the Quarantine Station at Point Nepean, died in May at his residence, 24 Albert Street, Windsor, near Melbourne.

GEORGE THOMAS TEAGUE, M.B. Melb., 1873, of Collins Street East, Melbourne, formerly honorary surgeon of the Melbourne Homeopathic Hospital, while driving in a buggy on June 21, came into collision with a lorry at the corner of Bourke and Swanston Streets, and received such injuries that he died the following day ; he was 37 years of age.

DR. J. F. WILKINSON, late resident medical officer at the Melbourne Hospital, has commenced practice at Bright, a gold-mining township, 200 miles N.E. of Melbourne.

DR. G. H. S. ZICHY WOINARSKI, of Donald, has removed to Brunswick Street South, East Melbourne.

DR. G. F. WICKENS, of Bright, on his leaving the district, was presented by the community with a handsome gold watch, gold albert chain and gold locket, as tokens of the high esteem in which he was held, both as a private citizen and an energetic advocate of public interests.

DR. W. E. YOUNG, late of George-street, Sydney, has commenced practice at 3 Collins-street East, Melbourne.

WE have received from Messrs. J. Lionel Ching and Co., of Sydney and Townsville, samples of Dugong Oil and Ointment ; the Dugong Oil, being almost tasteless, has been strongly recommended as a substitute for Cod Liver Oil by Dr. W. Hobbs, of Brisbane, and other medical practitioners in Queensland, who have given it a trial.

MR. L. BRUCK, of 35 Castlereagh-street, Sydney, has just received a supply of Dr. Oliver's Urinary Test Papers, such as albumen, indigo carmine sugar, and alkaline litmus acidity test papers ; also, nickel metal pocket cases containing the whole of Dr. Oliver's Urinary Test Papers, including specific gravity bead and tubes. These new test papers are very sensitive, and in the hands of the busy practitioner they afford a rapid and reliable bedside test, and obviate the inconvenience of carrying caustic fluids, which are, under any circumstances, very unmanageable pocket companions.

MEDICAL APPOINTMENTS.

- Byrne, Edward Henderson, L. Med. T. C. Dub., to be a Surgeon in the Queensland Defence Force.
- Carr, Michael, L.R.C.S. et L.K.Q.C.P. Irel., to be Public Vaccinator at Yarrawonga, Vic., vice Dr. A. A. Denis, resigned.
- Fitz-Henry, George William, M.R.C.S. Eng., to be Surgeon of H.M. Prison, Lyttelton, also a Public Vaccinator for the district of Lyttelton, N.Z.
- Fleming, Harloe Henry, M.B. et Ch.B. Dub., to be Public Vaccinator and Health Officer for the district of Donald, Vic., vice Dr. G. H. S. Zichy Woinarski, resigned.
- Floyer, Blaise Bernard, M.R.C.S.E., to be Government Medical Officer and Public Vaccinator for the district of Gulgong, N.S.W., vice Dr. J. P. Kealy, resigned.
- Gwynne-Hughes, Devereux, L.R.C.P. et R.C.S. Edin., elected Resident Medical Officer at the Sydney Hospital.
- Harston, Lionel de Courcy Eagles, L.R.C.P. Edin., M.R.C.S.E., to be Resident Medical Officer, Colonial Hospital, and Assistant to Superintendent of Vaccinations at Perth, W.A.
- Haynes, Edward James Ambrose, M.R.C.S.E., L.R.C.P. Lond., to be Government Medical Officer and Public Vaccinator at Gunnedah, N.S.W.
- Heuston, Benjamin Tydd, L.R.C.P. et R.C.S. Edin., to be Government Medical Officer and Public Vaccinator for the Sussex District, W.A.
- Jack, Robert Nelson, L.R.C.P. et R.C.S. Edin., to be Public Vaccinator for the districts of Lubeck and Glenorchy, Vic.
- King, Thomas Radford, M.D. Edin., to be Medical Superintendent of the Lunatic Asylums at Porirua and Wellington, N.Z., vice Dr. Levinge, transferred.
- Levinge, Edward George, M.B. Dub., L.R.C.S.I., to be Medical Superintendent of the Christchurch Lunatic Asylum, N.Z., vice Dr. Hacon, resigned.
- Macandrew, Herbert, M.B. et Ch.M. Edin., to be Surgeon to H. M. Prison, also Medical Officer of the Lunatic Asylum at Hokitika, N.Z., vice Dr. King, transferred.
- Macgibbon, Walter, M.D. Brux., L.R.C.P. et R.C.S. Edin., L.F.P.S. Glas., to be Public Vaccinator for Collingwood, Vic.
- Macnaught, John, L.R.C.P. et R.C.S. Edin., to be Public Vaccinator at Winchelsea, Vic., vice Dr. H. Meyer, resigned.
- Molloy, Charles Henry, M.B. et Ch.B. Melb., elected Resident Surgeon at the Alfred Hospital, Melbourne.
- Morison, Bentham Paynter, L.R.C.P. Edin., M.R.C.S.E., to be Medical Officer to attend to the destitute poor and aborigines within the district of Grace, S.A.
- Ross, William Chisholm, M.B. et Ch.M. Melb., to be Public Vaccinator at Werracknabeal, Vic.
- Scantlebury, George James, L.R.C.P. et R.C.S. Edin., L.F.P.S. Glas., to be Public Vaccinator at Linton, Vic., vice Dr. A. C. Robinson, resigned.
- Steven, Alexander, M.D. et Ch.M. Edin., M.R.C.S.E., to be Public Vaccinator at Collingwood, Melbourne, vice Dr. C. C. MacFarlane, resigned.
- Stevenson, Bernard, L.R.C.P. et R.C.S. Edin., to be Health Officer for district of Healesville, Vic.
- Stoker, Henry, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Health Officer for the district of Wycheproof, Vic.
- Tratman, Frank, M.B., Lond., L.R.C.P. Lond., M.R.C.S.E., to act as Government Analyst at Guildford, W.A.
- Wilkinson, John Francis, M.B. et Ch.B. Melb., to be Health Officer for shire of Bright, Vic., vice Dr. G. F. Wickens, resigned.
- Yeates, Edwards, L.R.C.S. Irel., L.K.Q.C.P. Ireland, to be Government Medical Officer and Public Vaccinator for the district of Warialda, N.S.W.

M.R. L. BRUCK, of 35 Castlereagh-street, Sydney, has just received a large supply of Hypodermic Pocket Cases, also of Hypodermic Tablets of every description.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards :—

NEW SOUTH WALES.

Gerrick, Herbert Percy Crittett, M.D. Bellevue Hospital, Med. Coll., New York, U.S.A., 1887.

Reddall, Osborne Henry, M.R.C.S. Eng., 1886; L.R.C.P. Lond., 1886.

For additional registration :

Bowker, Robert Ryther Steer, M.R.C.P. Lond., 1882.
M'Donagh, John Michael, L. Mid. R.C.S. Irel., 1883.

NEW ZEALAND.

Christie, William Ledingham, M.B. Univ. of N.Z., 1887.

Cook, Henry O'Brien, M.B. et Ch.B. Melb., 1886.

Innes, Charles Barclay, M.B. Lond.; M.R.C.S.E.

Mackie, William James L.R.C.S. Irel.; L. et L. Mid. K.Q.C.P. Irel.

Parsons, Harry Compton, L.R.C.P. Lond.; M.R.C.S. Eng., 1886.

TASMANIA.

Morris, Andrew Bernard, L.R.C.S. Irel.; L.K.Q.C.P. Irel., 1871.

VICTORIA.

Crivelli, Marcel Urbain, M.D. Paris, 1886.

McNaughton, John, M.B. et Ch.M. Edin., 1886.

Additional qualifications registered :

Halford, George J. A. B., Ch.B. Melb., 1887.

Woods, William C., M.D. Edin., 1886.

WESTERN AUSTRALIA.

Harston, Lionel de Courcy Eagles, L. et L. Mid. R.C.P. Edin., 1884; M.R.C.S. Eng., 1886.

Heuston, Benjamin Tydd, L. et L. Mid. R.C.S. Edin., 1871; L. et L. Mid. R.C.P. Edin., 1872.

Shiel, Edward Madale, L.R.C.P. & S. Edin., 1883.

Smith, Alfred Frederic, L. 1886, L. Mid., 1886, R.C.S., Irel.; L.K.Q.C.P. Irel., 1886.

PUBLICATIONS RECEIVED.

Report and narrative of the trial of Thomas Hall and Margaret Graham Houston, charged with attempting to murder Kate Emily Hall, held at the Supreme Court, Christchurch, New Zealand, before Mr. Justice Johnston and a special jury. Christchurch : J. C. Wheeler, 1886.

Papers on Hypertrophy of the Prostate Muscle. By Reginald Harrison, F.R.C.S. (Reprinted from the "Lancet," 1886.)

Colour Blindness and other Defects of Sight in some of their medico-legal aspects. By Jas. T. Rudall, F.R.C.S. Melbourne : George Robertson, 1887.

Oration delivered before the Alumni Association of the Medico-Chirurgical College of Philadelphia, on the evening of Thursday, April 7, 1887. By Dudley S. Reynolds, A.M., M.D., Louisville, Ky. (Philadelphia, 1887.)

Practitioners' Handbook of Diseases of the Ear and Naso-Pharynx. By H. Macnaughton Jones, M.D., M.Ch., F.R.C.S.I. and Edin. J. and A. Churchill, London, 1887.

Memorabilia. Issued by Fletcher, Fletcher and Stevenson, Holloway, London, N.

The South Australian Tourists' Guide : Containing accurate and full particulars of the Watering-places, Scenery, Shooting, Fishing, Sporting, Hotel Accommodation, etc., in South Australia. By Thomas Warsnop, Town Clerk. Adelaide : Sands and McDougall, 1887.

REPORTED MORTALITY FOR THE MONTH OF MAY, 1887.

METEOROLOGICAL OBSERVATIONS FOR MAY, 1887.

STATIONS.	THERMOMETER.						RAIN.		
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Mean Height of Barometer.	Depth.	Days.	Mean Humidity.	Prevailing Wind.
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	... 67·9	56	40·4	30·042	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	... 79·4	61	44·5	30·098	3·046	13	72	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	... 79·4	61	44·5	30·098	3·046	13	72	...	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	... 79·4	61	44·5	30·098	3·046	13	72	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	... 79·4	61	44·5	30·098	3·046	13	72	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	... 67·2	49·4	32·5	30·041	1·78	17	88	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	... 67	49·5	28	30·091	1·68	9	81	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	... 66	52·5	36·8	30·070	1·98	15	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.....	... 70·6	56·6	42·6	30·131	9·20	16	80	...	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	... 70·6	56·6	42·6	30·131	9·20	16	80	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

NOTES ON AUSTRALIAN SNAKE-BITE.

BY A. JARVIE HOOD, M.B. ET CH. M., GLAS.,
OF MACLEAN, NEW SOUTH WALES.

SINCE my arrival in the colony I have had under my care nine cases of reputed snake bite, all of which recovered, being, I think, a very strong argument that very few people die from snake-bite *per se*. One case, certainly, had a narrow escape, but the ligature which had been placed round the forearm, proximal to the bite, had been tied very tightly, and the arm for a time seemed likely to gangrene, and the part round the bite did gangrene. Had she died, however, it would certainly have been of septicæmia, not from the virus of the snake-bite. Soon after my arrival (3 years ago) I fortunately saw and read Hon. J. M. Creed's paper on the causes of death in cases of snake-bite, his opinion being that fear and alcohol were the two principal ones. I felt rather surprised and not at all sorry at his conclusions, for we home folk have always been taught to look on snake-bite as an injury from which few recover, and to be able to get rid of that feeling would be a great victory. I determined to observe carefully every case and see for myself if I could corroborate his opinion, and so far as my experience of nine cases warrants me, I can do so unhesitatingly. Every case recovered, and although I treated them all more or less in the usual orthodox way, viz., by cauterizing the bite, administering ether, hypodermically or by the mouth, giving sal volatile, &c., &c., still I think the recovery in all the cases was mainly due to my telling them *at once* that there was not the slightest danger or cause for alarm.

I shall only give a few notes of two cases as examples.

Case 1. Peter F., æt. 9, was brought to my consulting room about 12 months ago from some distance, in a cart, over a very rough road, driven at a rather rapid pace. His father stated that he had been bitten by a snake in the left great toe about one hour before. The boy was ashy pale, shivering, and cold perspiration was pouring off him: he could hardly speak above a whisper, and was altogether in a sad plight. There was a piece of twine loosely tied round his ankle, which his father informed me was a ligature his mother had put on to stop the poison getting into the blood! It had been put round the calf of the leg and had slipped

down. I examined the toe carefully and found only a small wound on the extreme tip of the toe, but as his father had scraped it with a knife I could not make out the nature of the original bite. (?) However I said at once that there was no danger, and that I did not think it had been a snake-bite, or if so, it had only been a small green or whip snake. Nevertheless to please the father I washed it and applied a drop of pure nitric acid and gave the boy m. x. of ether hypodermically. The following history was elicited from the boy with great difficulty and a great amount of coaxing. He had been walking barefooted in a paddock of long couch grass and suddenly felt a sharp sting on the point of the toe; he looked at the toe and saw a drop of blood on it, and thought a snake had bitten him, but he did not see a snake, and there were plenty of reeds and sticks about, any of which might have caused the wound. He ran home to his mother who tied the ligature on, and sent him in to me. From this story I felt convinced that if it were a snake it could not have been a poisonous one, or other symptoms would have developed ere I saw him; and I again assured the boy and his father that there was no danger. The boy had some marbles in his hand, and I offered to play him a game, to which he assented in a wondering whisper, and his father looked as if I were mad. However, we played at marbles for 20 minutes, by the end of which time the boy was as well and as jolly as a sandboy. My diagnosis in this case was: "Fear, perhaps complicated with a bite from a harmless snake."

Case 2. This patient, a Kanaka, rushed into my consulting room one morning dripping, shivering, and with a face which, for a blackfellow, was ghastly pale. I asked what the matter was and he said he had been bitten by a snake, and had run and walked about 3 miles, and swam a wide creek, to get to me. He was in a dreadful state of fear and cold, and thought, verily, that his time had come. I examined him carefully and found the marks of a snake-bite over calf of left leg. On further questioning I learned that he had been stripping cane, and while so doing a large, yellowish-brown snake, about (he stated) 6 feet long, fastened on his leg and bit him. He shook it off and came straight to me for assistance. From his description I was sure it was a bite of a form of carpet snake, and consequently harmless. This I assured him of, applied a drop of nitric acid to the bite to satisfy him that I had destroyed the poison, and gave him 3 i. of sal volatile in water. I then told him to go to his home, which was near at hand, put on dry clothes, get some hot tea, and then come back and see me. This

he did in less than an hour, and one could hardly believe it was the same man. He had resumed his dusky colour, was warm and smiling, and quite happy. In fact, he "was clothed and in his right mind." He stated that he was all right again, so I dismissed him.

These two cases are, I think, strong evidence in favour of Hon. Dr. Creed's conviction *re* the causes of death in cases of snake-bite, and personally his paper gave me great comfort as a practitioner and as an individual.

A CASE OF POISONING BY EATING PART OF A TOAD-FISH.

BY JOHN L. SPOFFORTH, M.R.C.S.E.,
L.R.C.P. ED.

THE deceased was a Chinaman named Ah Wy, about 42 years of age ; he resided in a hut about 14 miles from Manly, with another Chinaman, Ah Chin. On Saturday evening, January 15, 1887, they cooked about five fish which they had caught in the Hawkesbury River, making a dish of soup. One of the fish was about four inches in length and nearly as broad, it was spotted on the back, it could be blown up like a bladder, and if struck would burst and make a noise like a pistol. Both men ate of the soup at 7 p.m., but Ah Chin partook only of a little of the gravy. At 10 o'clock Ah Wy said that he was unwell and began to vomit ; an hour afterwards he asked his comrade to fetch some medicine. He went to a European's house and got some mustard and salt to form an emetic with ; on his return to the hut at midnight he found Ah Wy unconscious, and at 2 a.m. on Sunday he died—7 hours after eating part of the toad-fish. Ah Chin took some of the emetic. It seems that the reason for Ah Chin eating but little of the soup was that he did not consider that one of the fish used was wholesome, and he told this circumstance to his comrade ; the latter, however, said he believed it to be very good. A *post-mortem* examination was made by myself, which showed that the stomach was about three-parts filled with partially digested fish, and the mucous membrane was inflamed, chiefly at its pyloric extremity. The intestines were healthy ; the other organs of the body were considerably congested—otherwise healthy.

The toad-fish belongs to the genus *Tetraodon*, which is poisonous. Some of the fish belonging to this order are very good eating.

P.S.—The Coroner remarked that some years ago three children were poisoned by eating toad-fish, and died ; and that part of their vomit was eaten by cats, and they also died.

Argyle Place, Sydney.

ON REMOVAL OF THE TONGUE FOR CANCER.

READ BEFORE THE S.A. BRANCH, B.M.A.

BY W. GARDNER, M.D., HON. SURGEON, ADELAIDE HOSPITAL ; LECTURER ON SURGERY, UNIVERSITY OF ADELAIDE.

No subject in the whole range of operative surgery has given rise to more discussion than has been bestowed on the question of the best methods of removing the tongue for cancer. My object in reading this paper is to bring before you the methods I have found most useful, to compare them with other methods of operation, and to formulate, if possible, some guide for the future. In doing so I must crave your indulgence whilst I enumerate, shortly, the principal methods which have been introduced and recommended by the best surgeons of this century.

I. Whitehead's method of removal by scissors.

II. Removal by écraseur, adjusted behind needles, after splitting the tongue up the centre and dividing the muscular attachments at the front, sides and floor of the mouth, double threads being passed through the point of the tongue on each side of the frenum.

III. Bryant's method of removal with the galvano-cautery, which is used at a dull red heat.

IV. Jager's method, by splitting the cheek.

V. Kocher's method. This includes a preliminary tracheotomy, with ligature of the lingual and facial on one or both sides. An incision is made along the anterior border of the sternomastoid, from a point a little below the ear to the middle of the neck, then up to the hyoid bone and along the anterior border of the digastric to the jaw. The facial artery and vein and the lingual artery are tied, any glands enlarged are removed, and the mucous membrane along the lower jaw divided, and the mylo-hyoid separated from the bone. The tongue is then drawn out and removed with the galvano-cautery.

VI. Regnoli's operation. Submental incision from middle of the symphysis to the middle of the hyoid bone, and then two incisions running outwards from the chin end of this as far as the anterior border of the masseter. These flaps are dissected up and the insertions of the genio-hyoid and genio-hyo-glossal muscles divided with a straight knife thrust from below upwards. Then a blunt-pointed knife is passed in to divide the anterior insertions of the digastric, mylo-hyoid and mucous membrane as far back as the anterior pillar of the fauces. The tongue is then drawn through the submental wound and removed by

ligaturing, cutting off beyond the threads and searing with a hot iron.

VII. Operation of Chassaignac and Nunnely, of Leeds. Two curved needles are passed from below the chin through the tongue behind the disease; then a straight needle is passed up between them carrying the noose of an écraseur. The loop of the écraseur is then drawn up through the opening, the needle withdrawn, the loop of the écraseur widened out and passed behind the curved needles. The écraseur is then slowly tightened up from below the chin in the usual way.

VIII. Roux's, Syme's and Lédillot's method. By this plan the symphysis is divided, the tongue removed by the knife, and the bone united by silver wire wound round the teeth. Lédillot makes an irregular division of the jaw.

IX. Billroth divides the jaw and soft parts on both sides of the symphysis, turns down the flap of bone whilst removing the tongue, and then wires it.

X. Langenbeck divided the jaw and soft parts opposite the first molar tooth.

XI. Billroth also removes the tongue by a curved incision in the supra-hyoïd space, extending it well back, and omitting Regnoli's incision in the mid-line.

XII. Mirault introduced preliminary ligature of the lingual artery in 1833.

XIII. The plan which I adopt for cases of cancer on the dorsum and border of the tongue includes preliminary ligature of the lingual, with removal of glands when enlarged, and then removal of the tongue by Whitehead's method.

XIV. For cases involving the floor of the mouth I use Lédillot's method, after preliminary ligature of the lingual artery and removal of glands if necessary.

Statistics.

Billroth, 46 cases with 8 deaths.

Do. 20 cases (without ligature of lingual), 5 deaths.

Do. 20 cases (with ligature of lingual), 2 deaths.

Morrant Baker (with écraseur), 35 cases, 5 deaths.

Whitehead (with scissors), 28 cases, 4 deaths.

Kocher, 14 cases, 1 death.

I have operated 7 times without a death, and in each case have ligatured the lingual before removing the tongue, and have also removed glands when necessary.

Three times I have performed Lédillot's operation with ligature of the lingual artery, and four times Whitehead's operation with preliminary ligature of the lingual. The conclusion I have come to is that these operations cover the whole ground,

and are applicable to every case of tongue cancer suitable for operative treatment. The lingual artery is ligatured in the space between the posterior belly of the digastric and the posterior border of the mylo-hyoïd. The mucous membrane and muscles on the side to be removed are then separated from the lower jaw, after passing a double thread through the point of the tongue on both sides of the frenum. A curved, sharp-pointed bistoury is then thrust from the floor of the mouth through the base of the tongue and brought out on the dorsal surface. The tongue is then split by cutting forward in the line of the frenum to the tip, the tongue being placed on the stretch by the threads. The same knife or the scissors is then used to divide the tongue laterally beyond the diseased part. The bleeding is in nearly all the cases insignificant, and no artery has usually to be tied on the face of the stump.

If Lédillot's operation is necessary, the jaw is drilled on each side before dividing the symphysis, and after removal of the tongue the two sides are wired and a drainage tube is passed from the lowest point of the submental incision up into the floor of the mouth.

The after-treatment consists in frequently washing out the mouth with warm water, to which permanganate of potash has been added, and blowing in a powder consisting of one part of iodoform and three of coffee.

The advantages of these methods are:—

I. The preliminary ligature of the lingual lessens the risk of haemorrhage, and enables glands to be removed without in any other way increasing the risk of the operation.

II. The scar left is small compared with either Jager's or Kocher's operations, and it has the advantage over the latter that the wound made to tie the lingual artery does not communicate with the floor of the mouth, and is therefore free from the risk of being infected by the discharges from the mouth.

III. They have the advantage over the submental method that the tongue can be removed nearer the root.

IV. They have the advantage over the galvano-cautery and écraseur operations that they make clean incisions, and so avoid the sloughing of the surface which follows the use of either of these instruments, and there is less danger of secondary haemorrhage.

Mr. Butlin's work on diseases of the tongue contains the following passage:—"Unfortunately the least complicated operation for ligature of the lingual is far from easy, and the fear of abnormalities in the origin and course of the artery is not the cause which makes men unwilling to attempt

it unless they are almost driven to it. The large size and thin coats of the lingual vein, and the difficulty of drawing it thoroughly to one side or well above the line of the artery, the network of veins which sometimes lies immediately in front of the triangle, the difficulty which is in some cases experienced in clearly discovering the boundaries of the triangle, the oozing when the fibres of the hyo-glossal muscle are divided and when it is most desired to obtain a clear view, are only some among the many conditions which render ligature of the lingual artery one of the most difficult of operations for ligature in the human subject. Even on the dead body it is not easy, how much less so on the living subject with all the accompanying circumstances which render every operation for the arrest of actual haemorrhage difficult and anxious."

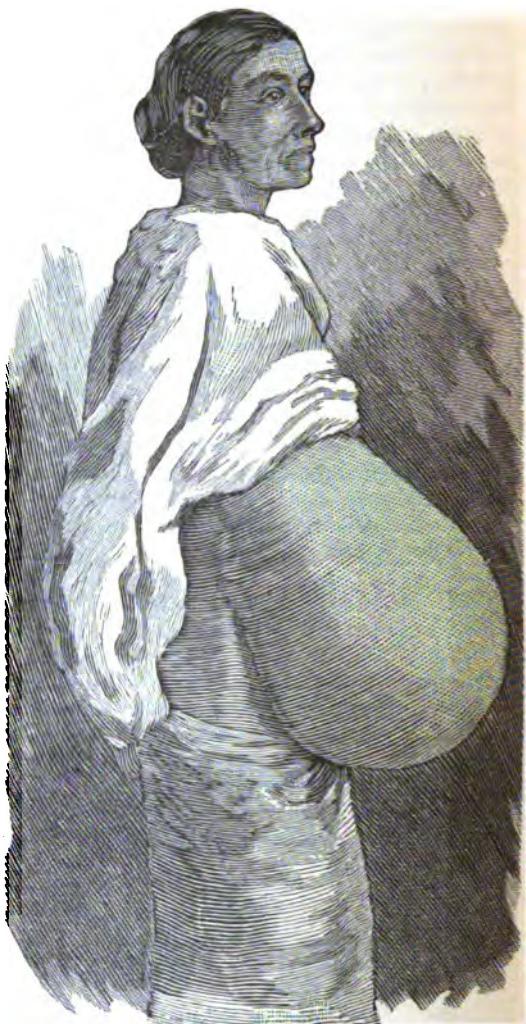
We must not, however, be discouraged by this, as I have ligatured the lingual eight times in seven operations (once on both sides, with removal of the whole tongue at one sitting); and we must also be encouraged by the fact that no artery in the body is less liable to abnormalities. The greatest difficulty, in my opinion, is caused by the vertical range of the hyoid bone in breathing.

A CASE OF PORRO'S OPERATION FOR FIBROID.

By Jos. FOREMAN, M.R.C.S.E., L.R.C.P. EDIN., OBSTETRIC PHYSICIAN AT THE PRINCE ALFRED HOSPITAL, SYDNEY.

E. N., 53 years of age, born in Greenwich, England; married at 20; menses appeared at 13½; before marriage they were irregular, occurring only about every six weeks, lasting about five days; always free, but sometimes she had great pain before they came on; after marriage they were still painful, but very regular. In 1873 she first noticed a swelling in the abdomen about the size of a saucer, in the right hypochondriac region, and at the same time suffered a great deal from soreness and swelling in the epigastrium due to dyspepsia. A few months later she had menorrhagia, which used to last from three to seven weeks at a time. This continued for two years. The tumour rapidly increased till it reached the level of the umbilicus. About this time she was tapped, but nothing could be withdrawn. Soon after the abdominal walls became stretched and the tumour began to rest on her thighs. Headaches and faint feelings were frequent, chiefly caused by loss of blood. The increase in size and the haemorrhage continued till May, 1886, when they ceased entirely up to the date of operation. The weight was a source of great

discomfort, and there was a very tender place on the right side. Micturition was difficult and she was subject to constipation.



The woodcut, taken from a photograph by Dr. Wood, of the Prince Alfred Hospital, does not show the typical abdominal face owing to its being a side view. The relative size of the tumour is well brought out. It measured 45 inches round the largest part and was hard and firm to the touch. On vaginal examination the cervix was felt very high up, and posteriorly, a hard mass, which exactly simulated faeces; but on rectal examination was found to be a separate growth, freely moveable, and extending into the pelvis. After consultation with the hospital staff it was decided to operate, as the discomfort was very great and the patient was anxious to be relieved of her

burden. The operation was performed on November 18 last, Sir Alfred Roberts, Drs. Goode and MacCormick assisting. The abdomen was opened by an incision extending from two inches above the umbilicus to the pubes, and the tumour turned out easily as there were no adhesions. The tumour, with the ovaries included, was caught by the chain clamp and the mass cut away. On the right side the ovary was flattened out into a long ridge, and continuous with it was a peculiar structure, about two inches wide, which gave one the impression of a bag of worms. A needle was put in and some clear fluid drawn off. This sac passed through the peritoneum at the pelvic brim, and not knowing what it was, but thinking it might be some strange cyst formation, I cut through the peritoneum and followed it up along the psoas muscle nearly as far as the kidney. Finding I could not get to the end of it, I ligatured it with strong silk high up and cut it away. The posterior opening in the peritoneum was brought together by a continuous gut suture. Tait's clamp was now put round the cervix which formed the pedicle; it was then trimmed, sufficient solid perchloride of iron used to dry it only, a glass drainage-tube inserted, and the abdominal wound closed. Iodoform was dusted round and dry cotton pads used as a dressing. The after-treatment calls for no special remark as the convalescence was uninterrupted, the temperature never rising over 100°, and the pulse keeping between 72 and 90—the latter on one occasion only. The pedicle separated on the 13th day.

The tumour was shown on the day of operation at a meeting of the Medical Section of the Royal Society. It weighed 38 lbs., and consisted of the uterus symmetrically enlarged, of dense fibrous structure, the centre of which was calcareous. The left ovary was about 6 inches by 4 inches, being of fibrous structure also, with a cyst containing about three ounces of clear yellow fluid. One of the chief points of interest was the condition on the right side which consisted of a varix of the ovarian veins. I have never seen nor heard of a similar case, and it certainly was very puzzling to all present. I see the patient very frequently; she is now stout and well and without any complaints.

WE have been requested to state that the opening meeting of the Intercolonial Medical Congress will be held in the Council Chamber at the Adelaide Town Hall. All the other and subsequent meetings will be held at the University, where there will be a Congress Office, to which members may have their letters addressed.

ON THE ACTION OF ACETANILIDE.
By J. CARNEGIE MACMULLEN, L.R.C.S.I.,
L.K.Q.C.P.I., &c., HONORARY PHYSICIAN,
AUCKLAND HOSPITAL, NEW ZEALAND.

I HAVE read with great interest, in the *Australasian Medical Gazette* for July, Dr. T. Carson Fisher's remarks on the action of the new drug acetanilide, or anti-febrine, as I have been closely watching its effects for some months past on my patients in the Auckland Hospital, chiefly in cases of enteric fever.

My own experience coincides entirely with that of Dr. Fisher as to the heat reducing properties of anti-febrine, and there is no doubt that it is a much more palatable medicine than antipyrine, smaller doses are more effectual, and its use is more free from the ill results than when the older drug is administered. I have not observed any remarkable effect either upon pulse or respiration, but have, in at least three of my own cases, observed a condition closely resembling collapse, and have heard of a similar state from other physicians here during the exhibition of the drug. I have also noticed that, in eighteen cases out of thirty, sweating was a marked and frequent effect, so much so indeed that in two cases I ceased to give the acetanilide, on account of weakness produced by excessive perspiration. I have not noticed either rash or diarrhoea produced by it, nor has the secretion of urine been sensibly effected. With regard to the collapse produced, it does not seem to follow on the amount of the drug taken, be it five grains or ten, but upon the temperature being past its maximum, commencing to decline, lysis having set in. It is at this time, and I have watched it narrowly, that collapse is apt to occur; it seems that now the effect of the drug is intensified, the falling temperature is doubly acted upon, and the usual weakness of the patient at this stage renders him peculiarly susceptible to the febrifuge properties of the medicine.

It seems strange to me that sweating was absent in all of Dr. Fisher's cases, because this effect of the drug was most marked, and usually, in about an hour's time after taking it, the patient was in a profuse perspiration, the drops of sweat rolling off the forehead and trickling from the cheeks. Several patients complained, when in this state, of feeling very hot, although the thermometer showed a fall of three degrees. The state of collapse, when it occurred, was marked by pallor of the face, cold extremities and small, feeble pulse, warmth, frictions and brandy having to be freely used to restore circulation.

It is true, as Dr. Fisher remarks, that new drugs are, as a rule, too highly extolled, only to

be hastily condemned, and I think, in both cases, without sufficiently careful trial and full observation, in numerous cases, of their effects. I consider anti-febrine a most valuable drug, cutting down fever in a remarkable manner, cooling and comforting the patient, perfectly safe if properly watched and the dose regulated from three to twelve grains, according to the state of the patient. The commencement of the lysis should be watched for, and the drug immediately withdrawn on its appearance. I consider acetanilide more useful in enteric than in any other fever, so far as I have had opportunities of judging.

THE PREPARATION OF ARTIFICIAL DIGESTIVE FLUIDS.

BY JAMES W. BARRETT, M.D., B.S., F.R.C.S.
ENG., DEMONSTRATOR OF PHYSIOLOGY AND
HISTOLOGY IN THE UNIVERSITY OF MELBOURNE.

MANY difficulties have hitherto stood in the way of demonstrating the process of artificial digestion, but the chief has been the difficulty of procuring active and efficient digestive fluids with the expenditure of a reasonable amount of trouble in their preparation. I propose then, in this communication, to indicate briefly to those interested, the manner in which artificial gastric and pancreatic juices may be prepared, and may be used either for demonstration to students or for per-

sonal experiment. Much of the matter has been collected with the kind assistance of Mr. Kirkland, Demonstrator of Chemistry in the University.

(1). THE PREPARATION OF AN ARTIFICIAL GASTRIC JUICE.

A very efficient gastric juice may be prepared by mixing 1000 cc distilled water, 2 cc strong H Cl., and 3 grammes of pepsin in scales (Fairchild).

If the quantity of pepsin in scales be increased to 5%, i.e., 5 grammes per 1000 cc, the action is very powerful. 100 cc of such gastric juice will completely dissolve 1 gramme of washed fibrin in 20 minutes, if maintained at a temperature of 35°—40° C. The percentage of pepsin in normal gastric juice is usually set down as 0·3%.

It is of course quite possible that this quantity of artificial gastric juice would dissolve a large quantity of fibrin, particularly if placed in a dialyser, but 1 gramme of fibrin is sufficient for demonstrative purposes when rapid action is required.

This artificial gastric juice coagulates the casein of milk very completely at 40° C., but whether this action is effected by the acid alone or by the acid and some trace of a ferment (rennet) in the pepsin in scales, I have been unable to decide. Artificial gastric juice has been used by the students in this laboratory with success.

The following table of directions to students in using it will show what service may be made of it. (These tables are published by the kind permission of Professor G. B. Halford.)

GASTRIC JUICE.

ACTION ON PROTEIDS.

(1)	(2)	(3)	(4)
Place in test tube 20 cc 25% H Cl. and a little fibrin. Maintain at 35°—40° C. during 30 min. Fibrin swells but does not dissolve.	Place in test tube 20 cc gastric juice (artificial) and a little fibrin. Maintain at 35°—40° C. during 30 min. Fibrin is digested and dissolved, being converted into acid albumen (para peptone) and peptone.	Place in test tube 20 cc artificial gastric juice, carefully neutralized, and a little fibrin. Maintain at 35°—40° C. for 30 min. The fibrin is not dissolved, i.e., pepsin does not act in a neutral medium.	Place in test tube 20 cc artificial gastric juice, previously boiled, and a little fibrin. Maintain at 35°—40° C. during 30 min. Fibrin swells but is not dissolved. The boiling destroys the pepsin.

COLD RETARDS THE ACTION OF PEPSIN.

Excess of peptone stops digestion; but dilution with weak acids then sets it going again.

ACTION ON PROTEIDS.

Take test tube containing fibrin which has been partially or completely dissolved. Filter. Neutralize carefully the filtrate, when para-peptone (acid albumen) will be precipitated. Filter.

ARTIFICIAL GASTRIC JUICE.—(Continued.)

(A)	(B)			
	FILTRATE CONTAINS PEPTONE, RE-ACTIONS.			
PRECIPITATE. May be recognised— Sol. in 5% H Cl. Sol. in 5% Na H O. Solutions are not coagulated on heating, but are re-precipitated on exact neutralization.	(1) Not coagulated on heating.	(2) Not precipitated on neutralizing with 5% Na H O.	(3) Add Millons' reagent. A red color on heating.	(4) Add K H O and 1 drop of 2% Cu S ₄ Sol. Purple coloration, unaltered by heat. All other proteins give a violet coloration.

TO PREPARE DIALYSER.

Fix parchment paper on the end of a broken test tube firmly; pour fluid containing peptone into this tube to the extent of $\frac{1}{4}$ -inch; place test tube into a beaker, and then add water until the fluid in the beaker and tube stand at the same level, but be careful that the water does not overlap edge of the parchment. Let this stand for half-hour. Peptone will be found in the water in the beaker on testing; thus indicating that peptone can diffuse through certain membranes.

(2). ARTIFICIAL PANCREATIC JUICE. (A). WITH REGARD TO ITS ACTION ON PROTEIDS.

An efficient pancreatic juice for use in effecting proteolysis may be prepared in two ways:—(a). By mixing 100 cc of a one per cent. solution of carbonate of soda in distilled water with 0·2 grammes of the newly-prepared ferment trypsin (Fairchild). 100 cc of such a mixture will dissolve 1 gramme of fibrin in from 15–20 minutes at a temp. of 35°–40° C. The action is more powerful than that of the artificial gastric juice referred to. (b). By mixing 100 cc of a one per cent. carbonate of soda solution with 1 gramme of zymine. 100 cc of such a pancreatic juice will dissolve 1 gramme of fibrin in rather more than one hour. The action of both zymine and pure trypsin occurs best in this 1% Na₂CO₃ solution.

(B.) WITH REGARD TO ITS ACTION ON STARCH.

100 cc of distilled water and 1 grammme of zymine form an efficient digestive fluid. Such a fluid will convert 1 grammme of arrowroot starch (in the form of mucilage with 50 cc of water) into dextrine and glucose in a few minutes at 35°–40° C.

Mr. Kirkland found that artificial pancreatic juice containing a small quantity of ferment, but with an alkalinity of 1% Na₂CO₃, acted similarly to a juice containing a large quantity of ferment, but with an alkalinity of 0·1% as regards proteids, but that the former was inert as regards starches, whereas the latter was active. The latter digestive fluid is therefore available for use in digesting either class of food.

The attached table illustrates the manner in which the work is done by the students in this laboratory with artificial pancreatic juice.

PANCREATIC JUICE.

ACTION ON STARCH.

(1)	(2)	(3)	(4)	(5)
Mix in test tube 5 cc mucilage and 2·5 cc pancreatic infusion. Warm to 35°–40° C. for 5 min. Mucilage becomes transparent. Granules disappear. Cu SO ₄ and picric acid tests indicate presence of glucose.	Same as (1), only render pancreatic juice alkaline by adding 5 cc 1% Na ₂ CO ₃ Sol., before adding mucilage. No glucose present, or only a trace. Compare with (1). The mucilage does not become transparent, i.e., the excess of alkali arrests the action on starch.	Same as (2), only after maintaining at 35°–40° C. for 5 min. neutralize with 5% H Cl., and again warm. Result same as (1), i.e., the action of amyllopsin was arrested by 1% alkali, but was not destroyed.	Same as (1), only rendering the juice acid by adding 5 cc 5% H Cl., before mixing with mucilage. Result same as (2), action of amyllopsin being arrested.	Same as (1), only boil pancreatic juice before adding starch mucilage. Result same as (2). The heat destroys the ferment.

PANCREATIC JUICE.

ACTION ON PROTEIDS.

(1)	(2)	(3)	(4)
Place 10 cc pancreatic juice in test tube, add some fibrin and 10 cc of 1 % Na ₂ CO ₃ , and maintain at 35°—40° C. until fibrin is dissolved. Fibrin appears first to corrode and then dissolve. Solution opalescent. Compare with gastric digestion.	Place 10 cc pancreatic juice in test tube, add some fibrin, and maintain at 35°—40° C. 1 hour, or add 10 cc 1 % Na ₂ CO ₃ in about 20 min. Fibrin dissolves less rapidly than in (1).	Place 20 cc pancreatic juice in test tube, add some fibrin, and then some concentrated pancreatic juice, containing no excess of alkali. Fibrin is dissolved more rapidly than in (2), almost as fast as in (1), i.e., the presence of excess of trypsin or of alkali produces similar results.	Place 20 cc pancreatic juice in test tube; boil it; when cool add fibrine, and maintain at 35°—40° C. for 1 hour. <i>Fibrin is unaffected.</i> Keep results of (1), (2) and (3), which contain peptones.

PANCREATIC JUICE.

ACTION ON PROTEIDS.—(Continued.)

Test for peptones: Mix (1), (2) and (3), filter. Render filtrate neutral with 5 % H Cl. and FILTER.

PRECIPITATE.	FILTRATE.	PEPTONE.
Is hemialbumose, a body closely allied with alkali albumen and casein.	(1)	(2)

Not coagulated by heat.	Not coagulated by strong acids or alkalies.	Add K H O or Na H O and 1 drop Cu SO ₄ 2 %. A purple color increased by heat. All other proteids give a violet color.
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PANCREATIC JUICE.

ACTION ON OILS AND FATS.

Experiments tending to prove that pancreatic juice does not of itself emulsify oils and fats. (KIRKLAND.) Its emulsifying power is due to the albumen present.

(1)	(2)	(3)	(4)	(5)	(6)
Place in test tube 5 cc pancreatic juice, which after 3 hours digestion has converted all albumen into peptone, add 2·5 cc of oil, shake well. No permanent emulsion. Solution becomes acid in 24 hours or more.	Place in test tube 5 cc H ₂ O and 2·5 cc oil, shake well. No permanent emulsion.	Place in test tube 5 cc 1 % Na ₂ CO ₃ and 2·5 cc oil, and shake well. Emulsion is more permanent than (2).	Place in test tube 2·5 cc dil. albumen (1—10) and 2·5 cc oil, and 2·5 cc H ₂ O, shake, a permanent emulsion is formed. Solution does not become acid on standing.	Place in test tube 2·5 dil. albumen and 2·5 cc pancreatic juice and 2·5 cc oil, shake. A permanent emulsion is formed, which becomes acid after 24 hours.	Place in test tube 2·5 cc dil. albumen, 2·5 cc pancreatic juice, warm at 35°—40° C., until albumen digested, i.e., when a portion of fluid does not coagulate on boiling. Then add 2·5 cc oil, shake well. No permanent emulsion. Solution becomes acid on standing.

In the preparation of these fluids there has been a tendency to make them more powerful than the natural secretions, for two reasons:—(1). They are usually used in glass vessels, and not in dialysers, and, consequently, their power progressively diminishes from the onset of their action. (2). The time at the disposal of a student is limited, and it is desired that the process shall be as rapid as possible.

CASE OF ACUTE BULBAR PARALYSIS.

By PERCY MOORE WOOD, L.R.C.P. LOND., M.R.C.S.E., SURGEON OF THE PALMERSTON HOSPITAL, PORT DARWIN, NORTHERN TERRITORY.

A. B., æt. 53, miner, from Kimberley gold-fields, Western Australia, was admitted into this hospital on Oct. 28, 1886.

Family History.—Father and mother dead, cause not known; no brothers nor sisters.

Personal history.—Widower. No children. No history of syphilis or alcoholism. Has had good general health, but has had malarial fever several times in North Queensland, and three years ago had sunstroke, and has since suffered from headache. Eight weeks ago had severe dysenteric diarrhoea, which has continued up to the present time, more or less. Six weeks ago he "poisoned" his finger, but by what means he does not know. Three weeks ago noticed numbness of his left hand, which has gradually increased so that he feels numb all over. For the last two days his tongue has annoyed him; he says that it feels like swollen.

Appearance on admission.—He is a thin, spare man, who looks older than he is, and the facial muscles seem very expressionless. All his limbs are weak, he can only just walk, but his left arm is almost powerless, however, he can feebly carry out all the movements, except raise it above his shoulder. He complains of feeling numb all over. Sensation impaired, most in the arm, but can tell the difference between hot and cold, and a sharp instrument from a blunt one. His voice is thick, and he attributes that to what he calls his tongue being too big for his mouth; can protrude it, and it looks normal. He can swallow, but as for the last two days food has constantly gone down the wrong way; he prefers to only drink milk. Pupils normal. Heart sounds weak, and there is slight systolic twist at the apex. Lungs seem both healthy. Liver, as known by percussion, normal. Spleen rather large. Bowels open four times, and passing blood. Urine, Sp. G., 1020; acid; cloudy; no albumen; E. T. 98·4.

Oct. 29.—M. T. 98. E. T. 98·8. Has more difficulty in swallowing; a piece of bread soon got between his teeth and cheek and had to remove it with his fingers.

Oct. 30.—All his limbs are weaker, can hardly move his left leg. Says anything he takes tastes dry. Can protrude tongue, but not quickly. M. T. 99·6, E. T. 100·2.

Oct. 31.—Has no desire for any food. No marked difference in his weakness. Urine, Sp. G. 1023; acid; slight albumen. Diarrhoea more under control. M. T. 98·8, E. T. 98·4, pulse, 100.

Nov. 1.—Complains of feeling as if an iron band was round his chest. Respiration more abdominal than normal. Mucous rales in both lungs. M. T. 99·6, E. T. 99·4.

Nov. 2.—Much weaker. Sensation generally much impaired. Complains of pain in region of his diaphragm, and more severely of the iron-band feeling. Cannot get rid of his sputa. Can protrude his tongue slightly. Passes his urine into his bed.

5 p.m.—Seems insensible. Pupils dilated. Skin dark and livid. Respiration entirely abdominal. Has not moved his limbs since the morning. Sphincter ani paralysed. M. T. 99·6, E. T. 99.

Nov. 3.—Died at 2 a.m., quite peacefully.

P.M. made six hours after death. Nothing apparently abnormal was found in the brain, cerebellum or medulla, with the exception that the choroid plexus of the fourth ventricle was congested. Could find no embolism in the basilar artery, and the cord showed no obvious change. Heart: muscular tissue was flabby, and there was a slight thickening of the initial valves. Lungs: left very congested; right very congested, but it also contained a hard fibrous patch, dark grey in colour, in no place soft, and the bronchial glands were enlarged and indurated. Liver, spleen and kidneys appeared healthy; large intestines inflamed and two small ulcers.

Remarks.—As far as I can find out, cases of acute bulbar paralysis are very rare, and this case is still more peculiar in as much as the tongue was nearly up to the last hardly affected. Treatment used was, first astringents, and then iodide of potash; but the disease was so acute that I doubt whether they were of any value. The growth in the lung appears to me like of a scirrhus nature. I have a small piece preserved in spirit, if any member of the profession would care to have it.

Palmerston, Port Darwin,
June 27, 1887.

A CASE OF NUTMEG POISONING.

BY ROBERT DENHAM PINNOCK, M.B. ET CH. M.
GLAS., BALLARAT, VICTORIA.

THE following case of Nutmeg poisoning may interest some of your readers, and I therefore record it.

The patient, Mrs. B., a strong, healthy woman, scraped rather more than half an ordinary-sized nutmeg and mixed it with a glass of hot ale, which she took at ten o'clock on the night of the 17th May of this year. She felt some nausea at half-past eleven when she went to bed, but went to sleep. Awakened at two in the morning feeling very cold and with a sensation of pricking in the skin, and with her heart beating at racing speed. She got up and walked about the room, although feeling drowsy all the time; but, after a time, feeling worse, she awakened her husband, who tried without effect to make her vomit with hot salt and water. I saw her at 4 a.m., and at that time the surface was cold everywhere; skin pale, pupils enlarged, respiration sighing, and pulse almost imperceptible and uncountable. I gave her hot brandy and water immediately, and mustard applications to epigastrum and extremities; also a mustard emetic. As this did not act, I gave her about fifteen minutes subsequently gr. $\frac{1}{2}$ of Apomorphia, which produced free vomiting in a few minutes. The vomited fluids contained nutmeg unmistakably. After this she improved, the pulse strengthening and steadyng, and warmth returning to the surface. She still, however, was very drowsy, and after taking some more hot brandy and water went to sleep. Next day she was much better, though a good deal prostrated and without appetite. The following day she was all right and attending to her household duties.

Several cases of nutmeg poisoning have been noted in the *British Medical Journals* of May 14, May 28, and June 11, of this year, and the writers state their inability to find any record of similar cases, or reference to nutmeg poisoning in any work on toxicology. The case I now record is noticeable first for the small quantity (rather more than half an ordinary-sized nutmeg) which produced the symptoms; and secondly for the very marked effect on the heart and circulation. A whole nutmeg was taken in four of the cases reported in the *B. M. Journal*, and five whole ones in the remaining case.

LARGE CYSTIC TUMOUR OF THE NECK.—COMPLETE REMOVAL BY OPERATION.—RECOVERY.

BY LOUIS FITZPATRICK, M.R.C.S., &c., MEMBER OF THE ROYAL IRISH ACADEMY, SURGEON TO THE QUEANBEYAN DISTRICT HOSPITAL, N.S.W.

I have the honour to submit for the perusal of the readers of the *Australasian Medical Gazette*, the following paper, which I trust is not devoid of some interest.

The generality of surgeons throughout the Australian colonies are more or less familiar with two special varieties of cystic tumours, viz.:—those occurring in the pelvic cavity and connected with the ovaries, and the *hydatid cystic* tumours found in most parts of the body, having no particular partiality. The latter are the most prevalent in New South Wales, for the obvious reason that the majority of the people drink water contaminated by dogs and horses, in whose bodies the ova of hydatids swarm. The form of growth which gives a title to this paper was not of either of the above varieties, and is comparatively rare on account of its position, rapid development, and extraordinary dimensions. Although decidedly a cystic tumour in its origin and capsular formation, it should be more correctly styled a *hydrocele of the neck*. It measured twelve inches by ten inches, and extended transversely from the thyroid gland to the lobe of the ear, and its point reached over the tip of the shoulder. It will thus be evident that the entire side of the neck was involved.

History.—Mrs. W., $\text{æt. } 20$, two years married, family history good, was first seen professionally by me on May 10th last, in consultation with her medical attendant, Dr. Richardson. She informed me that she noticed the growth three years previously, then only a small lump about the size of the hazel-nut. At this time it was treated by iodine applications and other internal remedies for some months, when, owing to their apparent uselessness, they were discontinued, and the patient, with a not uncommon apathy, ceased to adopt any other remedy;—unless indeed, we accept as “remedies” six electric baths, one box of pills, two powders, and a lotion said to be composed of “carbonate” of iodine, all recommended as a sure panacea by a Sydney electropath! The growth appears to have progressed only slowly for the first twelve months, but after marriage it enlarged rapidly, and having reached the size above stated, became so painful and unsightly that surgical aid was again sought. So painful had it suddenly become that she declared she could stand it no longer, and begged for relief. To the touch the tumour was intensely tense, and its covering red and

shining, and apparently stretched to its full capacity. Therefore, fluctuation could be only diagnosed with difficulty. In response to the prayer to do something, I advised puncturing with a view to withdraw some of the probable fluids and relieve tension. This was accomplished by the *aspirator*, which drew away nearly *two quarts* of a thick yellow, purulent pus. The relief was immediate. In order to allow the patient to recover strength further interference was postponed for a week. During this short interval it rapidly refilled, which fact convinced me that no remedy other than complete removal would be of any benefit. It must not be forgotten, however, that many eminent surgeons recommend other modes of treatment before resorting to removal of cysts—principally the practice of freely opening the cystic cavity, and endeavouring to cause contraction of the walls by the application of constant irritating injections. These means sometimes succeed by causing granulations to grow from the interior and finally fill the cavity when resorted to during the early periods of the growth. But, then, such process is long and tedious, and I consider more dangerous, owing to the tendency to inflame surrounding parts, and encourage erysipelas, which, in such a position, would be most dangerous.

At the kind invitation of my colleague, Dr. Richardson, to whom I am indebted for much valuable assistance, I operated in the following manner:—The patient was placed on a couch, with the head low and well thrown back over the right shoulder, according to the system advocated by Professor Annandale when operating in this region. By such means, all wrinkling of the skin is removed, and the cuts are clean. An incision two inches long was made in a slightly curved, longitudinal direction. This cut through skin, integuments and platysma-myoides facia, and exposed the cyst wall, which was gristly, and appeared to consist of tough elastic fibroid tissue. An aperture sufficiently large to admit my finger was made in this wall-covering, and I was enabled to explore the interior. The contents consisted only of the remains of the pus, which had been apparently too thick to escape through the trocar. This disappointed Dr. Richardson and myself, as we expected to discover some of those strange formations which have been so frequently extracted from the interior of cyst cavities. The walls were soft and velvety, but somewhat rugose. The feeling experienced can be best described as being intensely like that experienced when making a digital examination of the interior of the bladder. The flaps of skin and integument were carefully dissected back at each side and kept well apart by tenaculums. The cyst was now seen, when empty, to have contracted to the size of a large orange, globular in form,

and my endeavours to get round it by tearing with the handle of the knife, were completely frustrated by the extensive adhesions. These connected it to the sterno-hyoid, mylo-hyoid, and sterno-clido-mastoid muscles, and were so surprisingly dense that a critical dissection had to be continued with a sharp-pointed scalpel. I was obliged to proceed very methodically in order to avoid wounding the important vessels and muscles of this part, as any transverse division of the fibres of the latter would, most probably, give rise to the permanent deformity of wry-neck. This will be more readily understood when I mention that some of the attachments extended as deep as the clavicle. The final connection, close to the ear, was reached and detached from the jaw, half-an-hour from the beginning of the operation. The capacious cavity, formerly occupied by the tumour, was well washed with a solution of chloride of zinc, and the edges brought together by three sutures, these being covered in turn with dressings of carbolised lint and iodoform. The cut healed rapidly and healthfully, and the patient was able, six weeks after the operation, to go about the house, and attend to her own requirements.

It will be noticed that no allusion has been made to the vessels cut. I was surprised to find such a large growth supplied with only a solitary artery, at least I could only notice one, which was strong and spurted freely, but was controlled by twisting. It appeared to be a branch from the thyroid artery. We did not administer chloroform from judicious reasons, and the patient suffered a necessarily tedious and painful operation with a heroic and true womanly resignation.

The interesting features of the case are centred in the tumour's dimensions, twelve inches by ten inches—the largest ever seen by Sir Ashley Cooper being only the size of a cocoanut, which would be about half as large as the one under observation†; its rapid growth of not quite three years; its capsule nearly a quarter of an inch thick; its contents purulent pus, with a consistency of pea soup; its deep and dense adhesions, and its scanty vascular supply.

It may be mentioned, in conclusion, as an amusing incident of the case, and as showing the truth of the saying:—"a man is no prophet in his own country"—that some twelve months ago the patient travelled from Queanbeyan to Narandera a distance of near 700 miles, with the object of consulting a Chinese "Doctor." He, however, gave her but scant consolation, merely prophesying, with the heaven-inspired cant of the charlatan clan—"when lumpee bustee you die!"

† *Vide Cooper's Surgical Essays*, part i p 280.

TRACHEOTOMY IN DIPHTHERIA.

By P. T. THANE, L.R.C.P. LOND., M.R.C.S.
ENG., OF YASS, N. S. WALES.

THERE has lately been considerable discussion in the medical journals on the treatment of laryngeal diphtheria by tracheotomy, and also many successes due to this operation have been placed on record, the most noteworthy of these being the record of Dr. Crago, who, in *Australasian Medical Gazette* for December, 1886, and February, 1887, gives particulars of five cases in which he operated—four being successful. This, I should imagine, must be looked upon as a unique record, especially when we consider the late stage in all the cases in which the operation was performed. However, as it is as well often to publish failures as well as successes, I take the liberty of forwarding a few notes of a case in which I performed the operation.

M. M.—, a healthy girl of five years of age, was suffering from a cold for some days when, on the evening of May 13, "it seemed to turn to croup." The father, a man of good common sense, applied the usual remedies as he had to his other children when ill this way, using steam, hot baths and occasional emetics of vinum ipecac. The croupy breathing, however, continued, and was so severe on the night of the 15th that he telegraphed to me to come at once and bring instruments for tracheotomy, as he evidently foresaw that that probably, would only give the child relief. As he resides at a small township twenty-four miles from me I did not get the wire until late the next morning, and, upon my wiring to enquire how the child was, I got answer that she was better. However, in the afternoon, I received a telegram, asking me to go at once, which I did.

I saw the child in bed about 8 p.m. on the 16th. She then had severe and continuous laryngeal dyspnoea, the epigastrum, supra-sternal and supra-clavicular spaces being greatly retracted with each inspiration, and accompanied with that well-known and loud stridulous breathing; the face and lips were pale and countenance anxious; T., 98·6°; R., 48; P., 120, small, but stronger than one would expect from the history that this severe dyspnoea had been continuous for three days and nights; she was able to drink well, and, at times, quite lively; complained of no sore throat; had frequent "brassy" cough, with clear mucoid expectoration. On examining the throat, I found some slight swelling of the tonsils, and on each were small white membranous patches, not quite the size of three-penny pieces; the throat itself was remarkably free from inflammation, considering the presence of membrane; glands at angles

of jaw enlarged, but not tender; tongue moist, thin white fur; bowels had been freely opened after medicine. At times she was very restless, throwing her arms about and rolling in the bed.

My diagnosis was diphtheria, and I informed the father so, who asked me to do whatever I thought right. I might state that there has lately been quite an epidemic of diphtheria here, but I could hear of none in close proximity to the child.

Shortly after my arrival my patient was seized with a severe spasm, and was very nearly asphyxiated; in fact so severe was it that the mother ran out of the room, saying "she could not see her child choke."

Seeing the urgency of the case, and fearing that another spasmatic attack would be fatal, I advised tracheotomy, and at once performed it. I had the assistance of two lay gentlemen, one of whom held a candle for me, whilst the other continued the administration of chloroform, under my directions, after I had got the child under the anaesthetic. Before reaching the trachea, I had to divide a large vein running from below upwards and apply pressure forceps to the lower end; there was considerable haemorrhage, but this was checked before proceeding further. When the trachea was exposed, and I had inserted the hook to fix and steady it, the child had a very severe laryngeal spasm, and she commenced struggling and rolling in the bed; at this time I believe she could not have been thoroughly under the chloroform. All I could do was to wait until the breathing stopped completely, and then she was quiet. I then lost no time in opening the trachea, and fortunately had no difficulty in inserting the tube. It was some minutes before respiration recommenced—artificial respiration having to be performed for some time—and it was fully half an hour before it was properly established. No membrane was expelled through the wound, and the breathing through the tube was perfect. There was some slight discharge of thin, watery blood beside the tube for an hour or so after the operation, but no further haemorrhage. She was made comfortable in bed and slept soundly all night to 6 a.m., when I left her.

She woke occasionally at intervals, and drank milk and porter freely and easily; the latter she strangely had taken a fancy to, seeing her mother drink it. Sometimes when she drank, a very little of the drink would run out of the wound beside the tube, but never ran down into the trachea.

During the night there was only twice the slightest attempt at a cough, and the removal of a little blood-stained mucus on a feather at once relieved it.

When I left her, on the morning of the 17th, her pulse had fallen to 96; she was in good

spirits and smiling, and to all appearances, save for the tube in her throat, quite well.

I made arrangements to again visit her that night, but at 5.30 p.m., just as I was leaving, I received a telegram, saying she was dead.

Two days after I met the father, who said : "She simply seemed to fade away ; she was very cheerful all day, but towards the end she laid her head down on the pillow and her breathing got slower and quieter, until it stopped. There was no struggling whatever, and the tube never got choked. She took nourishment freely through the day." So that I must attribute death to adynamia.

There is one point which suggests itself to me: "Was I justified in performing the operation alone, and living, as I do, at such a distance from the child ?" It would have taken at least seven hours for me to have procured the services of another medical man, and, in my opinion, it was extremely improbable that she would have lived so long. There were so many points in the child's favour : She was five years old, a good age for tracheotomy ; she had always been strong and wiry, and was a most docile and manageable child ; her home was comfortable and her father accustomed to sickness—in fact, he is almost always consulted in the township before the people resort to a doctor. But yet I must admit, whilst performing the operation, I felt the responsibility press heavily upon me.

BULLET WOUND IN HEAD—SUBSEQUENT EPILEPSY—TREPHINED THREE YEARS AFTERWARDS—RECOVERY.

BY WALTER W. SPENCER, M.R.C.S.E.,
HON. SURGEON, BATHURST HOSPITAL, N.S.W.

JOHN WRIGHT, painter, æt. 28, consulted me for the first time in October last. He was then suffering from occasional epileptic fits, two or three per month, and had done so since the receipt of a bullet wound in the head, caused by the accidental discharge of a revolver ; this accident occurred on the 28th May, 1883, in England, and he was treated in the Leeds Infirmary. As there was, apparently, an aperture of exit, it was thought that the bullet had glanced from the skull ; the history of the accident favouring this view. The wound healed and he was discharged from the hospital, though he informs me that he had during that time several epileptic fits. The fits still continuing to occur he was advised to seek benefit to his health in a sea voyage, and he then emigrated to Australia. The change, however, did not prove beneficial.

On examining the head I could feel a well-marked projection immediately behind the right temporal ridge of the frontal bone, and slightly above the horizon of the orbital arch. This projection made more distinct by an adjoining depression that had been attributed to fracture caused by the bullet. As the fits had increased in frequency, so as to render him unable to follow his usual occupation, I advised him to undergo an operation, and this advice was confirmed by Dr. Cortis ; he, however, would not submit to the operation until he had communicated with his friends in England, but finding that the fits became of daily occurrence he determined to place himself in my hands.

I operated at the Bathurst Hospital, on the fifth of January, 1887, with the assistance of Drs. Cortis, Machattie, W. Pritchard Bassett, and McMasters. On opening the scalp with a V incision, and whilst reflecting same, the knife cut through lead on the surface of the bone. I then trephined, using the circular trephine ; from the situation of the part to be operated upon it was evident that there would be great inequality in the thickness of the bone to be sawn through, so great care was taken to make the margin of the saw near the temporal ridge bite the bone for some time before the other margin entered the osseous structure ; in fact, during the first stage of the section, the bone was penetrated on one side to the depth of half-an-inch before the opposite rim of the saw touched the skull. The central pin having been withdrawn the groove was gradually deepened until the inner table was penetrated and the included bone loosened and extracted in one piece, exposing the dura mater, under which the brain could be seen pulsating. The section shewed that lead had been cut through, the lead having penetrated the outer table and entered the diploë. I again applied the trephine on the side of the aperture shewing the section of lead, and removed another piece of the skull containing lead, as well as a fragment of the orbital plate, which was attached. The wound healed rapidly, and the patient had no fit until the seventh day after the operation. As there was some distension of the flap the wound was slightly opened, after which the recovery was uninterrupted and rapid. He was discharged after having been about a month in the hospital. Since the 12th of January, a period of nearly six months, he has had no fit and has been enjoying good health, earning his own livelihood for the past four or five months.

The section of bone was very deep, on one side measuring an inch, on the other less than half-an-inch ; this, though probably in some measure due to thickening of the bone, was caused by the direction in which the trephine was introduced at

the angle of the forehead. In the diploë can be distinctly seen the lead, which in its section was quite bright. The recovery I attribute not only to the relief of pressure, but to the removal of the lead, which seemed to have maintained more or less inflammatory action in the bone, such inflammation giving rise to irritation of the cerebrum.

Bathurst, June 30, 1887.

SCARLET FEVER OR DIPHTHERIA?

By W. T. HAYWARD, M.R.C.S.,
HON. MEDICAL OFFICER ADELAIDE HOSPITAL.

ABOUT six years ago I remember being much interested by an article in the *Nineteenth Century Magazine* on what would now be called Bacteriology—I forget what the title really was—by the late Dr. W. B. Carpenter, in it he alluded to the fact that cases at times occur which puzzle the best diagnosticians to say whether they are "Scarlet Fever" or "Measles." This remark was forcibly brought back to my mind a few weeks ago when I was called upon to attend the two following cases, brief notes of which I will relate.

Mary M., aged 5. On the 9th of December, 1886, the mother states that the child went to bed quite well, that she seemed out of sorts next day, and complained slightly of a sore throat; on the 11th she became feverish, and on the 13th a rash appeared, and she was delirious at night. On the evening of the 14th I first saw the child, she had then a temperature of 102, pulse 180, and she was covered from her neck to her feet with a bright red scarlatinal rash; there was decided hyperæmia of the fauces, with a follicular ulcer on the left tonsil. The tongue was coated with a somewhat dirty colored furr, the papillæ standing out near the tip and on the sides. There were no other marked symptoms or signs.

Dec. 15th.—Symptoms and appearance of rash about the same as yesterday; temp. 101·5, pulse 120.

Dec. 16th.—Temp. 102, but otherwise seems better; throat not so hyperæmic, nor tongue so coated; rash decidedly duller; sleeps better.

Dec. 17th.—Appears much better; temp. 100, pulse 110; rash almost disappeared; tongue cleaning rapidly; throat redness much less.

Dec. 18th.—Rash faintly visible; tongue clean; fauces normal; temp. 99, pulse 110.

Dec. 19th.—Seems almost well; temp. 98·4, pulse 100; urine, sp. gr. 1014, slight trace of albumen. From this time the child made an uninterrupted recovery. I saw her again about a

fortnight later, she then seemed in good health though rather anaemic; there were signs of desquamation, but not to the extent usual in cases of scarlet fever. No albumen was present in the urine.

Sarah M., aged 4, sister to above-mentioned child, was apparently well on morning of Dec. 12th, but seemed heavy at eventide; on the 13th was somewhat feverish and complained of sore throat. I saw her on the evening of the 14th, her face was then flushed, tongue coated, tonsils somewhat inflamed, with distinct thin diphtheritic patch on right one; temp. 101, pulse 124.

Dec. 15th.—Passed a restless night, slightly delirious; throat and tongue in similar condition as on previous day; temp. 100, pulse 120; no rash.

Dec. 16th.—Much better; tongue cleaner; swallowing not so painful; patch on tonsil as before; temp. 98, pulse 100; no signs of rash.

Dec. 17th.—Apparently quite well; tongue clean; slight traces of diphtheritic patch; congested fauces; pulse and temp. normal.

Dec. 19th.—Seems quite well; urine, sp. gr. 1014, no albumen. No further symptoms appeared in this case.

Remarks.—Of course the interest in these otherwise ordinary and simple cases centres in the fact that they occurred at the same time and in the same family; other details are also interesting; the parents keep a dairy and do most of the work themselves, the house they live in is a small three-roomed one, situated in a small, fairly thickly populated, narrow street; isolation was practically impossible, yet the two other younger children who had had neither scarlet fever nor diphtheria escaped infection. I could not trace the origin of the disease for there were no cases in the neighbourhood, neither did the disease spread in the street, nor amongst the customers who obtained milk from the dairy. The cow yard was clean and well kept; there was no disease among the cows.

As to the query with which I headed these notes, I confess that when I first saw these cases I had no hesitation in pronouncing them as scarlet fever, and I confidently predicted the appearance of the rash in the second case, but the result proved otherwise. I am now inclined to view them as diphtheria. I cannot help thinking that had the first case been scarlet fever, considering how terribly infectious this disease is, and how conducive to the spread of an epidemic the surroundings were, some other cases must have arisen. Diphtheria, on the other hand, is more of a contagious than an infectious disease, and would therefore be less liable to spread. I can, moreover, recall two other cases of decided diphtheria where a scarlatinal rash was present.

**ON OBSTRUCTION OF STENSON'S DUCT
AND ALTERED PAROTID SECRE-
TION.**

READ BEFORE THE N. S. WALES BRANCH, B.M.A.

BY R. SCOT SKIRVING, M.B., ASST. PHYSN. TO
THE PRINCE ALFRED HOSPITAL, AND HON.
PHYSN. TO THE SICK CHILDREN'S HOSPITAL.

My excuse for bringing this subject before your notice is its rarity, and the scant notice it receives in current literature of oral disease. The first case I will allude to is that of a lady who came to me complaining of a dry tongue, some difficulty in swallowing, and of a fulness under each zygomatic arch; these swellings being at times very painful. On examination, it was seen that the tongue on its dorsum was quite dry—that the breath was foul—and that the patient wore a double set of false teeth, the upper and lower parts of which were connected with a hinge fitted with a spring. This apparatus had been fitted the year previous. Opposite the second molar tooth of the upper jaw on both sides, I noted, in the buccal mucous membrane, a slight swelling, hardened and rounded, with a minute pin-point aperture in its centre. These were plainly the oral terminations of Stenson's ducts. Externally the infra-zygomatic swellings were situated in the line of the ducts. On the right side the swelling was acutely tender. Both parotids were full, and somewhat sensitive to palpation. The patient had unwisely been fitted with artificial teeth without a previous extraction of any of the old stumps, hence the secretions of the mouth were depraved and acrid. Finally, the most prominent part of each hinge, was the spot which exactly was in apposition to, and chafed against the orifices of the ducts. This led to inflammatory thickening, and practically a stricture had resulted. The treatment I adopted was slitting the narrowed orifices with a canaliculus knife, and then passing graduated filiform bougies up the tube. The character of the retained saliva was much altered. Indeed, the parotid half of the ducts were to all intents retention cysts, holding very viscous inspissated saliva.

Relief followed the treatment so far as the mechanical troubles were concerned, but the depraved condition of the saliva has not yet passed away, the parotid secretion being still much thicker than it should be.

Dr. Burne, dentist, of Lyons' Terrace, to whom I sent the case, agreed with me as to the cause of the stricture, and tells me the condition is a very rare one. I also find that a year ago he had refused to fit this patient with an artificial set, as he dis-

approved of doing so without first drawing the stumps. This the patient would not agree to, and going elsewhere got the work done without extraction. As I have not seen the case for some time, I am unable to tell you of her present condition.

The next case, also a lady, came to me with a letter from Dr. Cleaver Woods. Her condition was not so plain as to its causation, nor has it been so satisfactory as to treatment. Oddly enough these two patients came within a week of each other. The obstruction to the outflow of saliva was, in this patient, unilateral. It appears that some time ago she got into the habit of constantly chewing the right side of her cheek. This, I take it, caused such inflammatory action as to ultimately lead to a narrowing of the calibre of the duct. Although the actual orifice was stenosed, the most marked narrowing was about a quarter of an inch or thereby within the cheek wall. It appeared also, that at times a great amount of saliva was rapidly secreted, distending the duct, and causing the gland to swell. By pressure, the retained secretion could be made to spurt out of the little orifice well-nigh across the mouth. So much for the local condition, and the causation of the stricture. I slit up the mouth of the duct, and made it open into the mouth further back, and kept the channel patent by the passage of bougies. This, at least for the time she was under observation, relieved the mechanical difficulty. The retained saliva was an absolutely transparent, colourless, limpid fluid, more so than even normal parotid secretion. I regret that circumstances prevented me making any further examination of its character.

From Dr. Cleaver Woods, I learn certain interesting facts, which may have some connection with the hyper-secretion of the watery saliva, the stricture and consequent retention of the saliva being merely a determining cause, whereby one gland only was stimulated to abnormal functional activity.

This lady is at times very hysterical—usually about the monthly periods. These attacks are ushered in by symptoms like hay-fever—sneezing and catarrh of the frontal sinuses and nasal mucous membrane. Water pours from her eyes, and her physical condition is one of considerable excitement, the patient being described as well-nigh frantic for some time, and almost uncontrollable in her actions. This description I take from Dr. Cleaver Woods' notes. These attacks he considers are directly connected with the onset of the monthly periods. The hyper-secretion of parotid saliva, I must also add, is not necessarily preceded by, or simultaneous with, the coryza of the fronto-nasal mucous membranes. I carefully

examined the anterior nasal region and the nasopharynx. Nothing abnormal was noted, except the mucosa over the inferior turbinate bones, which I considered thicker and more velvety than usual. Is this condition a neurosis of the fifth nerve, or does it start in the naso-frontal mucous membrane itself? Is there any connection between it and the unilateral hyper-secretion of parotid fluid. The one-sided nature of the salivary affection being due to selection of that side from the pre-existing stricture and irritation of parts. Perhaps the simpler explanation is the best—that the two affections are distinct, and that the continuous hyper-secretion of saliva is merely the result of long continued irritation of the gland.

PROCEEDINGS OF SOCIETIES.

NEW ZEALAND MEDICAL ASSOCIATION.

THE Second Annual Meeting of the New Zealand Medical Association was held on May 11, at 4 p.m., in the Museum, Wellington. Present—Dr. Johnston (President), in the chair, and members of the Wellington Branch.

The President laid the following papers on the table, as being the business for the meeting :—1. Address by Dr. Johnston, President. 2. Receipt of Opinions of Branches, *re* Incorporation of N.Z.M.A. 3. Incorporation with British Medical Association. 4. Report of Wellington.—President and Secretary. *Re* Public Health Act (Vaccination). *Re* Registration of Midwives. 5. Right of Appeal by Detained Lunatics.—Dr. Hacon. 6. A Code of Medical Ethics.—Dr. Collins. 7. Amendment of Clause in Public Health Act.—Dr. Kemp. 8. Registration of Midwives Bill.—Dr. Hacon. 9. Act for the Establishment of the General Medical Council of Registration for New Zealand, and Branch Councils.—Dr. De Zouche. 10. Medical Attendance on Friendly Societies.—Dr. Dawson. 11. Proposed Medical Practitioners Association Bill for New Zealand.—Dr. Hacon.

The minutes of the last meeting were read by the Secretary, Dr. Fell.—Approved and signed by the President.

Telegrams were read, showing that, owing to stress of weather, the steamers both from North and South had been delayed, and that therefore the delegates from Auckland, Christchurch, and Dunedin, would not be here in time.

Proposed by Dr. Fell, seconded by Dr. Henry—“That the meeting be now adjourned until 4 o'clock to-morrow.”—Carried *nem. con.*

THURSDAY, 12TH MAY.

The Association met at 4 o'clock pursuant to adjournment.

Present—President (in the chair), Dr. Maunsell and Dr. De Zouche, representing Dunedin; Dr. Anderson, representing Christchurch; and the following members of the Wellington Branch: Drs. Cahill, Collins, Fell, Grace, Hassell, Henry, Hutchinson, Kemp, Levinge, Mahon, Rawson, Robertson, Tripe.

An address of welcome was read by the President. Dr. Maunsell replied, moving a vote of thanks for the

able address. Dr. De Zouche, in seconding this, said that to Dr. Coughtrey belonged the credit of having first mooted the idea of the Association; that Dr. Burrowes had urged its formation later on, and that it was finally brought into existence by the energy of the Auckland Branch.

Proposed by Dr. Grace, seconded by Dr. Henry—“That the address be printed and circulated.”—Carried *nem. con.*

Proposed by Dr. Fell, seconded by Dr. Johnston—“That one of last year's rules be amended as follows: Instead of reading ‘That the expenses be met by equal contributions from the *four* Branches,’ let it be ‘That the expenses be met by equal contributions from the existing Branches,’ omitting the word ‘*four*.’”—Carried *nem. con.*

Proposed by Dr. Johnston, seconded by Dr. De Zouche—“That each Branch Society should only have two votes.”—Lost on the voices.

It was decided that every member of the Association present should have a vote on matters of general interest, but that if any matter of purely local interest arose, then no Branch should have more than *two* votes.

Delegates were named from those present to act for the absentees, as follows:—Dr. Hutchinson and Dr. Kemp for Auckland; Dr. Cahill and Dr. Hassell for Nelson; Dr. Henry and Dr. Robertson for Invercargill; Dr. Levinge for Christchurch; Dr. Kemp gave notice of motion at the end of the business. Adjourned till 8.30 p.m.

The Association met at 8.30 p.m., pursuant to adjournment. Dr. Collins, vice-president, in the chair. The question of the incorporation of the N.Z.M.A. was introduced and discussed. It was decided by six votes to three to postpone the matter to the next meeting of the Association. The question of the incorporation with the British Medical Association was next discussed. As there was considerable difference of opinion it was finally carried, on the motion of Dr. Kemp—“That, in the opinion of this meeting, it is desirable that the question of the Incorporation of the New Zealand Medical Association as a Branch of the British Medical Association should be referred to the Branches, and their opinions considered at the next annual meeting.”

The report of the Secretary with regard to the two matters which had been submitted by the last year's meeting to the President and Secretary to bring before the Ministry was received. It was to the effect that, both in the matter of the amendment to the Public Health Act, relating to vaccination, and the Act for procuring the registration of midwives, it would be necessary to come before the Government with the views of the Association formulated and expressed in a form capable of being presented to the House.

DR. COLLINS, speaking for Dr. Hacon, unavoidably absent, moved for an Act relating to the right of appeal by detained lunatics. After consideration, the meeting decided that it was undesirable to alter the law at present. The meeting then adjourned.

FRIDAY, 13TH MAY.

The Association met at 4 p.m., pursuant to adjournment. The President in the chair.

Dr. Collins read the Code of Medical Ethics which had been adopted by the American National Association, and which was virtually the same as that recognised in Great Britain.

Proposed by Dr. Collins—“That the Code as read be accepted for the year, and printed, and a copy sent to every Medical Practitioner in the colony.” Nearly all members present spoke in favour of it, and the motion was carried *nem. con.* Certain amendments in the

clauses of the Public Health Act relating to Vaccination were proposed by Dr. Kemp, seconded by Dr. De Zouche. The general principles were approved by all present, and at 5.30 the meeting resolved itself into a Committee to consider them in detail.

The Vice-President took the chair.

Proposed by Dr. Kemp—"That Clause 139 of the Public Health Act be altered as follows:—'Any legally qualified medical practitioner shall be qualified to be appointed a Public Vaccinator, and, except as herein-after provided, no person who is not a legally qualified medical practitioner shall be appointed a Public Vaccinator.'"—Carried *nem. con.* "Clause 139, subsection 2: That after the word 'appointed,' the following be inserted:—'Provided that no unqualified person shall be appointed a Public Vaccinator except in districts where there is no legally qualified medical practitioner willing to perform the duties of Public Vaccinator, or in districts of so large an area that the one or more legally qualified medical practitioners cannot perform the duties as intended by this Act.'"—Carried *nem. con.* "Clause 132: 'The words 'unqualified person' shall mean any person not holding a degree, diploma, or license, entitling him to be registered under 'The Medical Practitioners Act, 1869,' or any Act amending the same, or passed for like purposes.''" "To insert the following:—'In districts, except as hereinbefore provided for, where there are or may be hereafter appointed legally qualified Public Vaccinators, the Governor shall, within thirty days from such appointment, cause the appointment of unqualified Public Vaccinators to be cancelled.'"—Carried *nem. con.* The meeting adjourned till 8.30 p.m.

The Association met again at 8.30 p.m., pursuant to adjournment.

Proposed by Dr. Collins, seconded by Dr. Hutchinson—"That a Committee be formed to interview the Premier, and endeavour to obtain his promise to push the above amendments. The Committee to consist of Drs. Kemp, Maunsell, Anderson, De Zouche, Tripe, Grace, and the mover."—Carried *nem. con.*

In the absence of Dr. Hacon, who was to have brought it forward, Dr. Fell introduced "A Bill for the Registration of Midwives in New Zealand," modelled on the English Bill. Although all the Branches were in favour of the measure, it was considered premature at present, owing to the difficulty that would be experienced in giving the women desiring to qualify a proper practical education. The Bill was negatived on the voices.

Proposed by Dr. De Zouche, seconded by Dr. Maunsell—"That an amendment to the Medical Practitioners Registration Act of 1869 is required, in the direction of a General Medical Council for New Zealand, with Branch Medical Councils in the four centres of Auckland, Wellington, Christchurch, and Dunedin."—Carried *nem. con.* A Committee was then formed to draft an Act for this purpose. The Committee to consist of Drs. Grace, Collins, Anderson, Maunsell, De Zouche, and Fell.

Proposed by Dr. Hassell (in the absence of Dr. Dawson of Auckland), seconded by Dr. Robertson—"That the following rules relating to medical attendance on Friendly Societies be passed:—"1. That after January 1st, 1888, no member of the New Zealand Medical Association shall accept as remuneration for his services to a Friendly Society a sum less than £1 per annum for each member, or member and family, of such Society." "2. That any Friendly Society paying less than the above amount shall not receive from a member of the New Zealand Medical Association the

advantage of a professional consultation when such is required." "3. That the above resolutions be forwarded to each Friendly Society concerned."

An amendment to this:—"That the question of the amount of fees to be paid by Friendly Societies to the medical officers be referred to the Branches," was proposed, and carried on the voices.

A proposed Medical Practitioners Association Bill for New Zealand was read, and rejected on the voices as unnecessary.

Dr. Kemp then made the motion of which he had given notice—"That notice of any subject to be discussed at subsequent meetings of the N.Z.M.A. be sent to the Secretary at least one month before the date fixed for such meeting, who shall thereupon cause such notices to be printed, together with the date of the meeting, and shall forward them to the Secretaries of the local Branches for distribution amongst the members. Subjects of which such notice has been given shall take precedence of all other business."—Carried *nem. con.* The meeting then adjourned till the following day.

SATURDAY, 14TH MAY.

The Association met at 4 p.m., pursuant to adjournment.

Report of Vaccination Committee.—"That Sir Robert Stout thought it unwise to open the Public Health Act question this session; that he would keep the amendment in view, and, whenever it became necessary or expedient to alter the Act in any way, he would endeavour to get Dr. Kemp's proposed alterations carried." The Registration Committee announced that they were now prepared with an Act. The Association resolved itself into a Committee to consider the provisions of the proposed Act. After much discussion the Act was agreed to; and it was decided that it should be printed and sent round to the Branches, in the hope that each Branch would influence the members of the House of its district to endeavour to get the Act passed next session. The meeting adjourned till 9 p.m.

At 9 p.m. the Association met again, pursuant to adjournment.

Dr. Maunsell asked the meeting to consider the advisability of sending representatives in Medicine and Surgery to Adelaide, to take part in the Medical Congress to be held there this year.

Proposed by Dr. Cahill, seconded by Dr. Grace—"That Dr. De Zouche and Dr. Maunsell be sent as representatives of the Association to Adelaide; but that this proposition be submitted to the Branches for their approval; and that a sum of £50 be set aside for their expenses."

The representatives of Auckland and Christchurch declined to pledge their constituents to any nominee, however desirable.

An Amendment was moved by Dr. Levinge, seconded by Dr. Anderson—"That the question as to the advisability of sending delegates to represent the N.Z.M.A. at the Adelaide Medical Congress, be referred to the local Branches, with an instruction that it had received the approval of the present meeting, and a request to nominate representatives in Medicine and Surgery, to be submitted for selection to the Council of the Association."

Dr. Hutchinson moved, as another amendment—"That the whole matter be allowed to drop."—Lost on division.

Dr. Levinge's amendment was put next.—Carried on division.

Dr. De Zouche read a letter from the Dental Association, to the Senate of the New Zealand University.

Dr. De Zouche moved, and Dr. Maunsell seconded—"That this Association approves of the recommendations of the letter."—Carried *nem. con.*

Proposed by Dr. Fell, seconded by Dr. Grace—"That the Association meet next year in Auckland, in the second week after the meeting of Parliament."

Amendments: 1. "That there be two meetings during the year, a summer one and a winter one;" 2. "That the next meeting be held in Christchurch."—Both lost on division.

Original motion carried.

Proposed by Dr. Hutchinson, seconded by Dr. Grace—"That the President and Secretary for the year be in future the President and Secretary of the local Branch at which the meeting is held."—Carried *nem. con.*

Votes of thanks to the President and Secretary were then passed; and, at 11 p.m., the President declared the meeting over.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY MEETING, held at the Adelaide Hospital, May 26, 1887.

Present:—The President, (Dr. Verco), Drs. Cawley, Gardner, Lendon, Mitchell, Poulton, Stewart, Symons, Wigg, Messrs. Aitken, Clindening, Finniss, Giles, A. A. Hamilton, Harvey, Lloyd, Vaughan, and the Hon. Sec. (Mr. Cleland).

The minutes of the meeting held April 28, 1887, were read and confirmed.

Ballot:—W. T. Angove, M.R.C.S. Eng., was elected a member of the S. A. Branch.

Mr. BORTHWICK forwarded a photograph of an infant 16 days old, born with partial absence of both fore-arms.

Dr. VERCO read notes of a case of pleuritis with effusion, and entry of pus into spinal canal.

Dr. GARDNER read notes on "Removal of the Tongue for Cancer," which will be found on page 266.

Mr. GILES asked Dr. Gardner whether he agreed with the extract from Mr. Butlin's work, which he had just read, with reference to the enlarged veins in the sub-maxillary region often seriously complicating the operation of tying the lingual artery. He had seen the operation performed frequently, and had never noticed any special inconvenience caused by the veins. It seemed to him the sub-maxillary gland, which was often greatly hypertrophied, gave rise to far more trouble, and sometimes made it very difficult to find the vessel. In one case he remembered Dr. Görger operating upon, the gland was enlarged, and the artery drawn up and fixed to its under surface, necessitating a prolonged dissection before it was found. He should also like to know, whether Dr. Gardner laid any stress upon the period in the operation when the rami of the lower jaw should be drilled. Was one's difficulty in any way increased by drilling the bone after cutting through the symphysis menti.

Mr. A. A. HAMILTON remarked, apropos of malignant disease of the tongue, that he might mention an interesting case which he had at present under observation.

Mr. T., at about 75. In September, 1886, a purple vascular growth about the size of a walnut was discovered on the dorsum of the tongue, about on a level with the anterior pillar of the fauces, in front and extending about half-an-inch backwards. Dr. Görger

who saw the case with me, suggested removal by the galvanic *écrasur*. The tumour, however, was so soft and friable that, while the wire was being adjusted, it broke down under the finger and came away piece meal. The stump was then thoroughly treated with the galvanic cautery. During the next two months the galvanic cautery was applied four times; fresh growths of the same purple colour as the original tumour springing up. During the latter part of December a fresh growth, about the size of a cherry reappeared. Early in January, I thoroughly destroyed this by the application of chromic acid fused on a pointed glass rod with which I perforated the tumour in different parts. Since the latter operation, now nearly five months, equally to my surprise and gratification, the tumour has not reappeared. There is, in its place, an indurated, healthy looking cicatrix. Neither Dr. Görger nor myself had the slightest doubt as to the malignant nature of the disease.

This diagnosis was based on the age of the patient, the rapidity of growth, and the haemorrhage which accompanied it, blood-stained sputa having been the first sign that there was anything wrong.

NEW SOUTH WALES BRANCH B.M.A.

THE 65th General Meeting of the Branch was held in the Royal Society's Room, Elizabeth-street, on Friday, 5th August, 1887, at 8.15 p.m. Present—The Hon. Dr. Creed (President), in the chair; Drs. Chambers, Clay, Clubbe, O'Reilly, Kendall, Munro, Macdonald, Pockley, Fisher, West, Garrett, Kingsbury, Worrall, Lovell, Twynam, Parker, Huxtable, and Scot-Skirving.

Visitor—Dr. Cortis, M.P.

The minutes of the previous meeting were read and confirmed.

The adjourned discussion on Dr. KENDALL's paper on Uraemia was resumed by Dr. WORKALL, who read some notes of a case of Uraemia.

Dr. CHAMBERS said the members were indebted to Dr. Kendall for having brought so interesting a subject before the branch. The discussion has centred more upon puerperal convulsions than uremic convulsions. It is stated by several writers that these convulsions are caused by the retention in the blood of excrementitious matter; but further research went to show that this was not quite true, as puerperal convulsions not only occur with women who pass large quantities of albumen, but also before there is any trace of albumen. In the majority of these cases he (Dr. Chambers) thought that the use of chloroform was far preferable to bleeding. The question then arises what is to be done with the uterus. He (Dr. Chambers) would suggest that so long as there is an indication of labour, let nature alone, remove tension by puncturing the membrane and then wait; but of course every case must be dealt with on its merits.

Mr. TWYNAM explained several cases that he had had under his observation in which the convulsions came on some time after the women had been delivered. In one case he (Mr. Twynam) had the opportunity of testing the urine, and found during the sixth and seventh months traces of albumen, but during the eighth and ninth months all appearance of albumen had ceased.

The President (The Hon. Dr. CREED) said that the point spoken of by Mr. Twynam was the one he intended to speak about, i.e., the cases in which the convulsions occur *post-parturition*. He (Dr. Creed) remembered a case in which the convulsions came on several hours after confinement, and caused him considerable anxiety, but after keeping the patient under

chloroform for about eight hours she recovered. The urine of this patient was nearly half albumen.

Dr. KENDALL thanked the members for the manner in which they had discussed the paper, and explained that his idea was to get the views of the members on this particular subject rather than to put forward any of his own ideas.

Dr. CLUBBE read a paper on "Osteotomy for bent tibiae," and exhibited the patient.

Dr. LOVELL said he had performed this operation, which was a very simple one, but had given it up, as he (Dr. Lovell) thought the risk too great, especially as quite as good results could be got without it.

Dr. CLUBBE also exhibited a case of congenital malformation of the sacrum and anus. This patient was carefully examined by the members present.

Dr. CLAY explained a case of congenital dislocation of both shoulders, with perfect movement. The patient was exhibited, and examined by the members.

The Hon. Secretary (Dr. SCOT-SKIRVING) then called the members' attention to the Report on the law respecting practice of Medicine and Surgery, and stated that the Council had passed the following resolution:—"That a sum not exceeding £25 be placed at the disposal of the Board of Health for the distribution of the Report of the Select Committee on law respecting practice of Medicine and Surgery," and would be glad of an expression of opinion as to the advisability or otherwise of the step.

Dr. GARRETT proposed, and Dr. POCKLEY seconded, "That the action of the Council in this matter is satisfactory to the members." Carried.

The President announced the election of Dr. THRING as a member of the branch.

MEDICAL SOCIETY OF QUEENSLAND.

THE Ordinary Monthly Meeting for June was held in the School of Arts, Brisbane, on June 14, at 8.30 p.m. Present—Drs. Bancroft (in the chair), Campbell, Taylor, Gibson, Hill, E. H. Byrne, W. S. Byrne, Hare, Shout, and Love (Secretary).

Visitors—Dr. Ralfe, of Melbourne; Drs. Mellish, King, and Hardie.

Dr. GIBSON showed a diphtheritic cast of the trachea, coughed up by a patient on whom he had performed tracheotomy.

Dr. LOVE then read for Dr. HOGG, of Goodna, a paper on the use of Paraldehyde as a hypnotic in contrast with Chloral. Dr. Hogg had made fifty-two (52) observations on patients in the asylum, and had found that with a dose of half-a-drachm, a sleep of the average length of nearly four hours was produced, and in only two cases was the dose quite ineffectual. With a drachm dose the average was nearly 5 hours. Dr. Hogg sums up thus:—Paraldehyde is a liquid with an acrid taste, and smell comparable to nitrous ether. It cost 1s. 6d. per fluid ounce, as contrasted with chloral, 5½d. The dose recommended is half-a-drachm to one drachm. He believes, judging from the result of his observations, that—

- (a) In doses of 3 i it is a fairly reliable hypnotic.
- (b) It can be given continuously without losing its effect or producing bad consequences.
- (c) It does not seem to possess any advantage on chloral.

Dr. BANCROFT called the attention of the members to a circular issued by some travelling American practitioners who intended visiting Brisbane. Dr. SHOUT moved, and Dr. E. H. BYRNE seconded, "That the

matter be referred to the Medical Board," which, after some discussion, was carried.

Dr. W. S. BYRNE mooted the subject of an annual dinner. It was suggested that the matter be left to the Council.

The ordinary monthly meeting for the month of July was held in the School of Arts, Brisbane, on July 12, at 8.30 p.m.; present—Drs. Bancroft, Rendle, Little, Hare, Tilston, W. S. Byrne, E. H. Byrne, and Love.

Visitors—Dr. David Hardie and Dr. Chas. Kebbell.

The minutes of last meeting were read and confirmed.

The President reported that the subject of the advertising quacks which had been brought up at last meeting had been laid before the Medical Board, and that steps were being taken for their suppression. A receipt signed by G. W. Ainslie, the president of the troupe, for £2, guaranteeing a perfect cure in three months, or agreeing to forfeit a sum of £100, was handed round.

The President reported that, owing to an irregular meeting of the Council (due to the bad weather), the question of an annual dinner had been deferred. After some discussion the matter was deferred.

The President gave notice that a printed circular on the University movement had been sent him by Sir Charles Lilley, asking the Society as a body to join in petitioning Parliament to establish a University of Queensland. Drs. BANCROFT, LITTLE, LOVE, HARE, W. S. BYRNE, and RENDLE joined in the discussion. Dr. RENDLE moved, and Dr. LITTLE seconded—"That the Medical Society of Queensland thinks it premature to express any opinion as to the advisability of starting a University at the present time." Dr. W. S. BYRNE moved as an amendment, seconded by Dr. LOVE—"That the Medical Society give the University scheme its cordial support." It was agreed after some discussion to postpone the division to a fuller meeting.

Dr. RENDLE showed the upper half of a foetus, at about the fourth month, which had been amputated in utero.

Dr. HILL showed a very perfect specimen of a foetus at the third month, with membranes entire.

Dr. LITTLE then read a paper on the treatment of certain forms of chronic alcoholism, which will be published in our next issue. Drs. BANCROFT, LITTLE, TILSTON, BYRNE and LOVE joined in the discussion.

The following gentlemen were unanimously elected members of the Society:—Drs. Lauterer, Mellish, King, Hardie and C. Kebbell.

REVIEWS.

ON FEVERS: THEIR HISTORY, ETIOLOGY, DIAGNOSIS, PROGNOSIS, AND TREATMENT.

By ALEXANDER COLLIE, M.D., WITH COLOURED PLATES. London: H. K. Lewis, 1887.

This appears to be a period in the publication of books specially distinguished by the production of uniform series. And whether in medicine or in the wider field of general literature, the numbers of such a series are certain to possess very unequal value. Some few supply a felt want and are of considerable intrinsic merit, while the *raison d'être* of others, apart from the idea of uniformity, would be difficult to find.

But there is a third category embracing volumes

like that under consideration, which, without special claim to the highest merit and originality, form useful and valuable handbooks, and whose appearance may be welcomed by a large section of the "busy practitioner" class who may find it difficult to find the time necessary for the study of more profound, or at least more pretentious, treatises. It is indeed highly important that such manuals as the present should be accessible, and it is doubtless chiefly with a view to satisfying this want that Mr. H. K. Lewis has planned the Practical Series of which this handsome little volume forms a number. It professes to give an account of the History, Etiology, Diagnosis, Prognosis, and Treatment, of the various forms of fever from the point of view of modern medicine. The chapters upon the different fevers are written with great clearness, and present the facts in the form of a concise yet thoroughly readable statement, divided into sections under the several headings referred to. The text is illustrated by the reproduction of temperature charts, and by a number of coloured plates of clinical or pathological modifications, but the character of the plates is not of the highest order. While the writer exhibits in his own statements all the freedom and confidence of an extensive clinical experience, he makes frequent quotations from the writings of acknowledged authorities, and it must be admitted that this adds to the value of the pages, but references ought invariably to have been given. In the introductory chapter upon "Fever," the writer discusses its relation to the germ theory, towards which he assumes an attitude which is at least *critical*. We confess to a certain disappointment with the book in regard to this subject which is so intimately connected with the pathology of fevers. The author seems hardly to have realised the profound influences which the germ theory has had upon modern conceptions of zymotic disease. It is rather strange to find oneself now-a-days in an atmosphere which is by no means inimical to the theory of spontaneous generation, and which finds the first principles of the germ theory still matters of dispute.

But if the author is unsatisfactory in his treatment of the deeply interesting pathological questions, his treatment of the more practical aspects of the subject will be found to be most sound, and characterised by clearness and vigour. He adduces some carefully sifted evidence in favour of the infectious character of enteric fever, but he hardly succeeds in showing that the practical danger from it is very great. Throughout the book there is much incidental information—historical, statistical, &c.,—all of which tends to enhance the value of the book, and to fit it for the use of those to whom it is more specially addressed.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which is found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reach Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JULY 15, 1887.

EDITORIALS.

THE REPORT OF THE SELECT COMMITTEE ON THE PRACTICE OF MEDICINE AND SURGERY IN N. S. WALES.

On March 10 a Select Committee was appointed by the Legislative Council of New South Wales, on the motion of the Hon. J. M. Creed, consisting of Sir Alfred Stephen, C.B., G.C.M.G., Lieutenant-Governor, and the Honorable A. Dodds, A. Jacob, P. G. King, J. E. Salamons, J. Norton, J. Stewart, W. H. Suttor, J. B. Watt, and the mover, "to enquire into the state and operation of the laws now existing for the regulation of the practice of medicine and surgery in New South Wales." The Editor of this journal was elected chairman, and the committee at once entered upon its labours. Evidence was given by the Dean of the Faculty of Medicine, (Professor Anderson Stuart, M.D.), the Medical Adviser to the N. S. Wales Government (Dr. MacLaurin), the President (Dr. Mackay), and the Secretary (Dr. Houison), of the Medical Board; and then by a series of men who are practising in Sydney without possessing any qualifications, and in most instances without having gone through any professional training. The committee continued its enquiries to the end of the session, and on July 12 the chairman brought up a progress report, which said that though sufficient evidence had "been elicited to show the urgent necessity of an extensive amendment in the existing laws," the Committee desired to continue its enquiries before

making its final report, and therefore recommended a resumption of the enquiry at an early period of the ensuing session. The evidence given by the quacks themselves, who were summoned before the committee to tell their own history, is most startling, and it has aroused public attention in the colony to a remarkable degree.

The lay newspapers have devoted considerable space to the subject, and have published articles strongly pointing out the obvious necessity of immediate and stringent legislation. The Sydney *Daily Telegraph* is republishing the evidence *verbatim*, and the demand for the paper has been, in consequence, extremely large.

It became evident during the enquiry that, in New South Wales, any man may set up as a medical practitioner without let or hindrance, that the evidence of men without qualifications is accepted in the Law Courts, and before coroners, as that of medical experts; that poor professional "ne'er-do-wells" of weak character, but possessing qualifications, are made use of as screens by designing scoundrels, and that there is no means of punishing either the one or the other. That under the existing law men once placed on the register through fraud cannot be removed, and, to our knowledge, there are numerous instances of this at the present time. One thing which excites surprise is the apparent disinclination of the Crown Law Officers, to aid the Medical Board in giving effect to the very limited power which it possesses; this is shown by several instances where the Board desired assistance in prosecuting offenders of a particularly glaring character, but in no case was any action taken, though in one instance recommended by a Supreme Court Judge. The difficulty which is experienced in New South Wales, of deciding as to whether a man, claiming to be so, possesses diplomas or not, is shown by the facts that one man whose only training had been three months' residence in the house of a man knowing but little more than himself, was called by the police as a medical witness at a metropolitan Police Court, and the same man was directed by the acting City Coroner through the police, to make a *post-mortem* examination in a case of sudden death, because he had a brass plate on his door with Dr. before his name. This man, as he stated in his evidence, did not make this examination, because he was not capable, never having received any training. If the police do not possess the requisite knowledge to discern the qualified from the unqualified, how is it possible that the general public can know? The exposure of the gross frauds daily being perpetrated on ignorant and unsuspecting, but extremely credulous, people, has been so effectively exposed by the committee, that legislative action by the Go-

vernment must follow—and that very speedily. Our space is so limited that we cannot republish the report and evidence, consisting as it does of upwards of a hundred closely printed foolscap pages. It is of the utmost interest, and we recommend all our readers to obtain a copy,* and to bring it under the notice of their neighbours.

FEMALE MEDICAL STUDENTS.

THE Council of the Melbourne University, at a meeting held on the first of August, was much exercised in its mind by the receipt of the reply of the Faculty of Medicine, relative to an enquiry made as to the provision of separate means of instruction for female students. The Faculty very decidedly expressed its opinion that the only practicable method for instructing lady students, would be by allowing them to enter at the ordinary classes with the male students, and this opinion we fully endorse. What we have always said we still say, that ladies should have equal facility with male students for the study of medicine, and they should suffer no disadvantage nor receive any favour on account of their sex. We think young ladies who are of the right stamp to make efficient practitioners, are quite able to take care of themselves, though constantly and intimately brought into contact with the opposite sex, so that there is nothing to fear on their account; it will be the males who will be in the greatest danger of fascination, but we see nothing for it but to warn them that their fate will be in their own hands, and, as they make their bed so they must lie in it. If there ever should be any truth in the old saying, that the world has three sexes, viz.: men, women, and doctors, we think it is in this instance that it might be acted on with practical advantage. Amongst the councillors who are most horrified at the proposal of mixed classes are a Mr. MacFarland and Mr. Ellery, the Government Astronomer. We regret that the latter should have exhibited so little good sense in his remarks at the meeting, and can only hope that he will study the well-being of the University in matters medical, by ceasing to interest himself in sub-lunary affairs, and that instead he will stick to the stars, where he is so much at home.

* Copies of this Report (postage paid), may be obtained by writing to Mr. Bruck, of 35 Castlereagh Street, Sydney, on enclosing 4s. ed. in stamps.

THE BRITISH MEDICAL ASSOCIATION IN TASMANIA.

We are pleased to know that it is proposed to found a branch of this society in Tasmania, and that a provisional committee, consisting of Drs. E. L. Crowther, Perkins, Giblin, Butler, Gray, Payne and Elliott, with Dr. Smart as president, and Drs. Parkinson and Wolfshagen as secretaries, has been appointed. A medical society was urgently needed in that colony to bring the various members of the profession into friendly contact, and to create a medium for the report and discussion of cases of interest. It will also establish an authority to which matters in dispute between individual members might be submitted to a neutral and kindly authority for decision. It cannot fail to keep up, if it exists, and to bring about, if it is absent, that friendliness amongst its members which is so essential to the well-being of a learned profession, and which is perhaps of greater value in that of medicine than any other. We wish the new society every success.

THE QUALIFICATION FOR HONORARY SURGEONS AT THE MELBOURNE HOSPITAL.

At a recent meeting of the committee of the Melbourne Hospital a question arose as to the eligibility of licentiates of a college of surgeons for appointment as honorary surgeons to this institution. Mr. Gregory, who was one of the sub-committee which drew up the rules, said that it was intended to exclude licentiates as ineligible, which, to say the least of it, is rather an anomaly when it is borne in mind that one of the most brilliant surgeons who has held an honorary appointment at the hospital for upwards of twenty years, until very recently held no other qualification than the L.R.C.S. Ireland. Licentiateship of the Colleges of Surgeons in Edinburgh and Dublin is equivalent to the Membership of the College in London, and it would be not only absurd, but unfair, to make distinction between the diplomas merely on account of the name. As to the L.A.H. of Dublin it has been the custom to register it in these colonies as a qualification entitling its possessor to rank as a legally qualified practitioner; but this is not the case in the United Kingdom, where it is of a very inferior value to the L.S.A. London, and is supposed merely to authorise its possessor to dispense medicine and to treat minor ailments.

CROSS v. GOODE.

The reserved judgment of the Full Court in this case was delivered at the Supreme Court, Sydney, on July 25. It was an application by the defendant for a new trial in a case of malpractice, which has been refused. This decision appears to have been arrived at by their Honors after considerable doubt, for they are reported to have said, "If the result be unsatisfactory to the Court, as they confessed it was, what guarantee had they, should the case be submitted to another jury, that the result would be in any degree more satisfactory?" We can only express our regret that the Court has arrived at this decision, for evidence would have been submitted at a new trial which would, we think, have put a different complexion on the case. In our issue for April, 1886, we went fully into the case, and we see no reason to change the opinion we then expressed, in fact, further consideration and extended inquiry but tends to strengthen it. We think it our duty to express our great sympathy with Dr. Geo. Goode in what we fear is now his inevitable misfortune.

THE WATER SUPPLY OF THE WESTERN SUBURBS OF SYDNEY.

SINCE the mains have been completed to Sydney from the new Prospect Reservoir, a commencement has been made to reticulate the western suburbs, and so place them in possession of a good water supply, independent of local sources. The corporation of Ashfield, when the work was commenced in that borough, made so energetic a protest, that operations have been stopped. In our opinion, nothing could be more suicidal than this policy. Enteric fever has been for a considerable period rife in these suburbs, and it would have been the greatest aid to its being lessened, could the water supply have been obtained from other than local sources. In the vast majority of cases, enteric fever can be traced to a contaminated water supply, either a well into which fecal matter containing the specific germs has percolated, or a tank which, having been negligently puddled externally to its brick and cement lining, has cracked, and become permeable to outside water; this source of danger is much more frequent than is generally supposed, and with the close proximity of the closet to the well or tank, necessitated by the small allotments on which the houses are built, is always highly dangerous. The objections made are that the laying of the pipes is breaking up the streets,

and that they do not wish to pay for what they believe they can do without. As a mere matter of economy, a water supply from a distant unoccupied source is most desirable, for an outbreak of enteric fever would cost a hundred fold as much, not only to the family concerned, but to the corporation, leaving out of sight altogether the danger to which that human life is exposed, which is always spoken of as so sacred, and which loud-voiced philanthropists continually express themselves as so anxious to protect, when it does not cost them anything beyond words.

A GUIDE TO THE HEALTH RESORTS IN AUSTRALIA, TASMANIA AND NEW ZEALAND.

OUR readers will be pleased to learn that Mr. Bruck, well-known as the author of that invaluable book of reference, "The Australasian Medical Directory and Handbook," is now preparing a *Guide to the Health Resorts in Australia, Tasmania and New Zealand*. Mr. Bruck proposes to divide this work into six parts, viz. :—

- I. Climatology of the various Australasian Colonies.
 - II. Alphabetical List of all known Health Resorts in Australia, Tasmania and New Zealand, giving a general description of the Climatic Health Resorts, Spas and Watering-places, with their environs, special indications, analyses, the names of resident medical men, and the addresses of hotels and boarding-houses worthy of recommendation, the quickest and cheapest routes, and other useful information.
 - III. Classification of Health Resorts named, according to their respective Colonies, with remarks on the physical aspects of the various Colonies.
 - IV. Classified List of Health Resorts named, according to their therapeutic indications.
 - V. Alphabetical List of Diseases, showing where they are most effectually treated.
 - VI. The New Zealand Thermal Springs districts.
- With an Appendix, containing the names of Specialists of repute, and of Consulting Physicians and Surgeons resident in Australia, Tasmania and New Zealand, with their addresses, specialties, &c.

With their great variety in temperature, owing to the wide range of latitude under which these Colonies lie, and the numerous mineral and thermal springs, and sea-bathing places to be found in all parts of Australia and New Zealand, there can be no question that the proposed guide is imperatively needed, and that, as a Book of Reference, it will prove of great value to members of the medical profession, to invalids, and to a very large class of tourists throughout the Colonies.

To judge from the promised contents, as enu-

merated above, this new guide will be most complete in information, and being compiled by Mr. Bruck, one so thoroughly conversant with the subject, the profession may look forward to a guide, concise and yet comprehensive, and as accurate and practical as it well can be.

LETTERS TO THE EDITOR.

THE REPORT OF THE COMMISSION ON THE BULLI COLLIERY EXPLOSION.

(To the *Editor Australasian Medical Gazette*.)

SIR,—I beg to call your attention to an item of this report of some interest to the profession, viz., the statement by Dr. L. (at the inquest), "that the shreds of cuticle on the hands of one of these bodies had preserved its elasticity shows that the body having been forced along the rough floor, but the skin had been untouched by flame."

When they were seen by Dr. Llewellyn and myself the cuticle of the palm was gone, a flap of about $2\frac{1}{2}$ ins. by $\frac{1}{4}$ in. adhered at the wrist and projected like a frill, the cuticle of the palmar aspect and between the fingers was detached, lying in puckered folds. It was black from coke-dust burnt into it and could not be removed. No abrasion of the cutis, no scratches, no imbedded coal-grit, nor any sign of mechanical friction was observable. I am informed by Mrs. Jones (the woman who attended to the laying out of the bodies) that the hair of this boy's head (the particular body alluded to by Dr. L.) was burnt, leaving bristles only $\frac{1}{4}$ inch long, and that his skin on the back was like roast pork. The face of No. 5 was denuded of cuticle and of a vivid scarlet colour. The cuticle of No. 2 was hanging about the ankle like a sock. A witness told the commission that the head of one of these bodies had only short bristles, and he was not sure if there was any skin (cuticle). The only point about which I had the slightest doubt was whether any of the burning occurred after death, but on careful consideration I am of opinion that all, or nearly all, occurred immediately before and at the instant death took place; that most of the appearances could have been produced immediately after death, and that if they had lived ten minutes the evidences would have been much more marked. I believe that if any of the 81 miners had been got out of the pit alive, nearly the whole of the cuticle would have blistered or desquamated.

I went to the mine to make a more thorough examination by day-light, and was informed by the coroner in the shed in which the bodies had been placed by my directions, that "the sergeant considered the cause of death so plain that my evidence would not be wanted;" so I left in disgust. I volunteered my evidence at the inquest, when I was informed that Dr. L. had stated that the bodies were not burnt.

I am, yours truly,

T. J. STURT, M.D. Lond.,
Formerly Lecturer on Materia Medica
University of Melbourne,
Govt. Medical Officer, Bulli.

Bulli, N. S. Wales, July 19, 1887.

A NEW EPIDEMIC.

(To the Editor A. M. Gazette).

SIR,—I have read with interest Dr. Macdonald's communication in the July number of the *A.M.G.*, on the subject of a "New Epidemic." I know the locality about which he writes, and have the pleasure of being slightly acquainted with himself. The township called "Prospect Reservoir" is a vast camp. What the population of it was may be guessed from the fact that at one time there were about 3,000 men employed on the works (there are not so many now). Most of these lived in tents or in rudely constructed huts, and their notions of sanitation were as primitive as their dwellings. Last year was very wet, and the summer, as usual, pretty hot. Now, given these three factors:—A ground saturated with noxious excrement, abundance of rain to moisten it and keep alive the germs, and a high temperature to foster and propagate them, what result might naturally be expected? Malaria? Yes, and also typhoid fever, cholera, diphtheria, &c.; malarial fever is not uncommon in these parts, and it frequently exists side by side with typhoid. In Mudgee, in the beginning of 1886 I had five members of one family down with fever, not exactly simultaneously, but all about the same time. One daughter had typhoid fever complicated with pneumonia, another had malarial fever, one son had uncomplicated typhoid, and another and the mother had malarial fever. I understand typhoid fever was prevalent at Prospect camp this last summer, and I am of opinion that the cases Dr. Macdonald describes were a form of malarial fever; I have seen a good deal of it in the West Indies, and some of the cases were identical in their symptoms with those Dr. Macdonald describes. Jaundice, which Dr. Macdonald says "most particularly identifies the disease," is a marked characteristic of malarial fever—so much so that it is often difficult to draw the line between a bad case of malarial, and a mild case of yellow fever. With the exception perhaps of pain in the right hypochondrium the other symptoms referred to are not of any diagnostic value, being common to almost all fevers. Although Dr. Macdonald may not agree with me in holding that it was malarial fever he had to deal with, I agree with him generally as to the correctness of his treatment. "Purgatives, enemata, anti-pyretics and local treatment for the pain," were certainly indicated. So also was the line of dieting adopted, and the stimulants to counteract prostration but I do not notice in his article any reference to quinine. This is regarded by some doctors in the West Indies as the one reliable remedy in malarial, just as it is in intermittent fever, and they give it in heroic doses, five, ten, even twenty grains. My favourite treatment in the early stages was calomel and jalap to relax the bowels and bring down the bile, then a powder composed of calomel, nitre, and James's powder to abate the fever, and lastly, quinine in five to ten grain doses dissolved in nitro-hydrochloric acid, with the addition of three or four minims of Fowler's solution, and infusion of quassia for vehicle, the latter being itself a germicide febrifuge. In the cases of men accustomed to stimulants, tincture of capsicum was added, to make the stomach retain the food and medicine. I may add that with this treatment I never lost a case.

Yours,

J. DIAMOND, M.D., &c.,

Belmore Terrace, Oxford-street,
Sydney, 5th August, 1887.

COCAINE POISONING.

(To the Editor of the A.M.G.)

SIR,—The article in *A.M.G.* on the above will probably be sufficient excuse for my notes on an isolated case.

On Tuesday 26th, I gave a gentleman of nervous temperament, and a total abstainer of several years' duration, about $\frac{1}{4}$ grain of cocaine hydrochlorate (powder), directing him to rub small quantities on the gum in order to allay the pain of a carious tooth. He had used the whole in the course of two hours by applying small quantities at a time. In less than three hours after applying the first modicum he complained of excessive pain in the head (occipital and frontal), with general debility or tremor, amounting at the knees to inability (to a limited extent) to support the body-weight. In a few hours all the symptoms disappeared.

It is just, in this connection, to state that a pill containing one grain of opium, administered for diarrhoea, caused much headache and sickness, and that the gentleman in question eats freely. The opium effect was probably due to disturbance of stomach in some degree, the diarrhoea having been due to a temporary irritation from errors in diet. However this may be, the nervous results from the grain of opium appeared to be very much exaggerated, making the administration of the drug in future a matter of special care. His digestive organs are active, yet he suffers occasionally from slightly jaundiced conjunctiva (duodenal catarrh), owing in great measure, no doubt, to his diet. There is also the factor *nervous worry*, which, however, is important as regards his appetite.

The full notes of this case will, I trust, lead to similar action on the part of others, and to more extended observations on the use of the drug.

JOHN REID, M.A., M.D.

Melbourne, August 1, 1887.

THE MONTH.

NEW SOUTH WALES.

AT a meeting of the Senate of the University of Sydney, held on July 4, Professor Anderson Stuart moved the following resolution, of which he had given notice:—"That the Senate, recognising the status of the Faculty of Medicine as an integral portion of the University, has no intention of allowing the study of medicine to be in any way dissociated from the influence of the University." After some discussion, Professor Gurney moved the following amendment:—"That the Faculty of Medicine be informed that the Senate has not in contemplation any action which would tend to separate the Faculty of Medicine from the rest of the University." Professor Stuart, having by leave withdrawn his motion, seconded the amendment. The Chancellor moved, as a further amendment, that the following words be added to Professor Gurney's amendment:—"That the Senate desire that a more ample provision should be made for the medical school of this University, and, having regard to the report sometime since received from the medical faculty as to its further requirements, is prepared to use its influence for procuring such a provision as will suffice to place it in a position of equality with the medical schools of the highest class elsewhere." Professor Gurney's amendment, without the proposed addition, was subsequently carried.

AT the monthly meeting of the Board of Directors of the Prince Alfred Hospital, held on July 14, the following resolution, with reference to the establishment of a tutorship, to afford clinical instruction to the students, was adopted, "That, in the event of it being considered necessary to have a medical tutor to afford primary clinical instruction to the students at the hospital, it is desirable that the University and hospital should contribute equally to his salary; that each student pay a fee of two guineas for the instruction, and that all such fees be paid to the general hospital fund." It was resolved that a copy of the above resolution should be forwarded to the Senate of the University of Sydney. The rules under which the tutor should hold office, introduced by Professor Anderson Stuart, were read by him and discussed by the board.

AT the request of Lady Brassey a special meeting of ladies and gentlemen interested in the St. John's Ambulance Association was held at Government House, Sydney, on July 18, with a view to establish a centre of the association for New South Wales, under the immediate patronage of Lord Carrington, to which the branches of the association already in existence in the colony are to be affiliated. At a subsequent meeting held in the Town Hall it was decided to form a head centre of St. John's Ambulance Society in Sydney. Lord and Lady Brassey were among the speakers and intimated their intention of becoming life members together with Lord and Lady Carrington.

WE have been requested by Mrs. Gurney, honorary secretary of the Sydney Home for trained Nurses, to state that the Home has been removed from 52 to 140 Phillip Street.

IN March, 1886, a brickmaker named Cross, brought an action in the Supreme Court against Dr. Goode, then of Camden, for alleged negligent treatment in regard to a dislocated shoulder, when a verdict was found by a majority of the jury in the plaintiff's favour with £500 damages. A rule nisi for a new trial was subsequently applied for, on the ground that the verdict was against evidence, and also on the ground of improper reception of evidence; the Court delivered their reserved judgment on July 25, and while confessing that the result of the first trial was highly unsatisfactory, yet, they could not see their way to grant a new trial, the rule, therefore, was discharged with costs.

JOHN WILLIS SMITH, herbalist, practising at No. 10 Macquarie-street South, Sydney, was arrested on July 26 on suspicion of having caused the death of Cissy Bradshaw, a young domestic servant, by administering a poisonous drug; at the coroner's inquest on July 29, the jury returned a verdict that death resulted from poison administered by him, and he was committed for trial on a charge of murder. However, he was released from custody on August 6, the Attorney-General having declined to file a bill against him.

ON July 20, a complimentary dinner was tendered to Dr. Madden at Moss Vale, by the local lodges, as a welcome back to the district after 15 months' absence in Tasmania.

DR. H. G. A. WRIGHT, of Sydney, the victim of the recent criminal conspiracy, was, on July 15, presented, at his residence in Wynyard Square, by Sir Alfred Roberts, Kt., on behalf of the medical profession, with a purse of 155 sovereigns and an address of sympathy. At the presentation there were present the Honorable J. M. Creed, M.L.C., Professor Anderson Stuart, Drs. MacLaurin, Schwarzbach, Cox, Knaggs, Quaife, Garrett, Chisholm, Ward, Marshall and Laure.

HERBERT CHATWORTH HALLOWES, M.R.C.S. Eng., 1881, L. et L. Mid., R.C.P. Edin., 1882, of Launceston (Tas.), while on a visit at Bourke, died suddenly on July 6, through the bursting of a blood-vessel.

AT a coroner's inquiry, on August 8, into the death of a child, which, in the opinion of Dr. Wright, had died from a poisonous dose of opium, a verdict of manslaughter was returned against Hugh S. St. George, an unregistered practitioner, who practises at Ultimo, and who had treated the child.

DR. W. R. CORTIS, M.L.A., of Bathurst, has removed to Sydney; prior to his departure from Bathurst he was banqueted by the leading residents of the town.

DR. J. DIAMOND, late of Mudgee, has commenced practice at Belmore Terrace, 298 Oxford-street, Paddington, a suburb adjoining Sydney.

DR. D. T. EDMUND has succeeded to the practice of Dr. W. R. Cortis, at Bathurst.

DR. PHILIP SYDNEY JONES has been elected a Fellow of the Senate of the University of Sydney, in the room of the Hon. Sir Alfred Stephen, K.C.M.G., resigned.

DR. J. P. KEALY, late of Gulgong, has removed from Inverell to Tamworth.

DR. H. S. LLOYD, late Junior House Surgeon at the Adelaide Hospital, has commenced practice at Hunter's Hill, a suburb on the Parramatta and Lane Cove rivers, 4 miles from Sydney.

DR. JAS. McNISH has commenced practice at Burwood, a fashionable suburb 7 miles from Sydney.

DR. R. MORROW has commenced practice at "Cintaff," Queen-street, Ashfield, a suburb of Sydney.

DR. ALEX. PATERSON has established himself as a specialist in diseases of the Genito-Urinary Organs, at 29 Bligh-street, Sydney; at the same time Dr. Paterson will carry on his general practice at Stanmore as before.

DR. A. C. ROBINSON, late of Linton (Vic.), has commenced practice at Jerilderie, on the Billabong creek, in a pastoral and agricultural district, 416 miles S.W. of Sydney.

NEW ZEALAND.

AT the annual meeting of the Dunedin Branch of the New Zealand Medical Association, held on June 29, the following office-bearers were elected for the ensuing year:—President, Dr. Colquhoun; Secretary, Dr. Gordon Macdonald; Treasurer, Dr. Davies; Librarian, Dr. Ogston; Committee, Drs. Hocken, Copland, and De Zouche.

DR. LEWIS KEELE HORNE, of Blenheim (Prov. Marlborough), one of the oldest settlers in the district, is supposed to have perished in the disastrous fire which broke out in the Criterion Hotel of that town, where Dr. Horne resided, and who was missed after the fire had been subdued.

DR. W. E. HACon, of Christchurch, who recently retired from the position of Medical Superintendent of the Sunnyside Asylum for the Insane, after an honourable career of nearly seven years, received from the former Inspector of Asylums, Dr. Graham, before he left for England, a very flattering letter, expressing to Dr. Hacon his entire satisfaction with the management of Sunnyside Asylum, and with the improvements by Dr. Hacon, which have given this particular institution the highest position in New Zealand as a Hospital for the Insane.

DR. R. H. BAKEWELL, late of Hokitika, has removed to Auckland.

QUEENSLAND.

DR. WM. HOBBS, who has occupied the position of Government Medical Officer at Brisbane for 34 years, has been granted 12 months' leave of absence on full pay. It is understood that he will retire from the position at the end of that period, in consequence of failing health.

EDMUND FRANK, who has been practising as a doctor and dispensing medicines at Rockhampton without possessing a certificate from the Queensland Medical Board, was fined £20 at the police court on July 29, the prosecutors being the Queensland Medical Board.

HENRY HOLCROFT, M.R.C.S. Eng., 1882, late of Sydney, and formerly of Newcastle, died at Brisbane on July 14, at the age of 31.

DR. S. H. EDGELOW, of Rockhampton, has removed to Croydon, the centre of rich gold-fields in the north of Queensland.

SOUTH AUSTRALIA.

SMALL-POX has broken out at Palmerston, Port Darwin; seven Chinamen have been quarantined. Every precaution has been taken to prevent the spread of the disease.

DR. T. D. ATKINS, late of Rosedale (Vic.), has settled at Balaklava, on the river Wakefield, 67 miles N. of Adelaide.

DR. W. H. BARKER has commenced practice at Mintaro, 82 miles N. of Adelaide.

DR. N. W. HOLMES, late of Western Australia, has settled at Kingston, on the shores of Lacepede Bay, 169 miles S.E. of Adelaide.

DR. A. RICHARDSON, of Teetulpa Gold-fields, has removed to Glenelg.

TASMANIA.

FROM January to the end of June, 1887, 388 persons suffering from typhoid fever were treated in the various hospitals of Tasmania; the percentage of deaths to cases was 10·70.

VICTORIA.

AT a meeting of the Council of the University of Melbourne, held on August 1, a letter was received from the Medical Faculty transmitting applications from two medical students for recognition of their attendance on the surgical practice of the Brisbane Hospital. The faculty also reported that the Brisbane Hospital had not yet been recognised by the University of Melbourne, and had made no formal application for such recognition. It was resolved that the students be informed that the Brisbane Hospital must make application to the University for recognition, and, at the same time, forward the requisite particulars for the guidance of the Council.

FROM the annual report of the managers of the Alfred Hospital for 1886-87, we learn that the number of patients under treatment during the twelve months ending June, 1887, was as follows:—In-patients, 1,727; out-patients, 2,041; casualties, 640; total, 4,408. The number of prescriptions dispensed during the year has been 37,168, showing an increase of 2,521 on the previous year. The daily average of in-patients (exclusive of those in the pay wards) has risen from 114·6 last year to 141·7. This extraordinary increase is in part due to the Camp Hospital, and also to the fact that the Linay Pavilion was only opened for patients towards the close of the last financial year. The pay wards, to which reference was made in last report, were opened

for the reception of patients on 2nd August last, and have, up to the present time, been fairly well patronised. Of the 118 patients admitted since the opening, 85 were discharged, relieved or cured, and 19 died, leaving 14 inmates on the 30th June, 1887. Twenty-five of the foregoing patients occupied class A wards (*i.e.*, private rooms), and 88 patients class B. The former paid £4 4s. and the latter £2 6s. a week, including in each case £1 1s. a week for medical attendance. Owing to the exceptionally severe outbreak of typhoid fever that occurred early in the year, the Central Board of Health requested the co-operation of the managers to place at its disposal a portion of the hospital grounds for the erection of a fever camp, and to supply the needful medical attendance and nurses. The tents, six in number, and containing in all 28 beds, were opened on 18th February, and closed 26th May. During that time 69 patients (57 male and 12 female) were treated, of whom 49 were discharged after recovery, 12 transferred to the hospital wards, and 8 died.

DURING the 18 months, ending June 30, the number of patients treated at the Victorian Eye and Ear Hospital has been as follows:—In-patients, 653; out-patients, 18,542; new cases, 4,153; and total attendances, 22,695. The number of operations amounted to 963.

THE committee of the Medical Society of Victoria has reported Dr. J. W. Springthorpe, M.R.C.P. Lond., to the Royal College of Physicians, in London, for alleged breach of professional etiquette in issuing a self-laudatory circular in connection with his candidature for appointment to the position of Honorary Physician to the Melbourne Hospital at the forthcoming election.

THE committee of management of the Melbourne Hospital has made application to the Lands Department for 10 acres of land within the University reserve, and adjacent to the Women's Hospital, as a site for the new Melbourne Hospital.

FROM November, 1886, till June, 1887, 292 persons suffering from typhoid fever were treated in the Alfred Hospital, Melbourne; during that time the death-rate was 13·01.

JOSEPH FREEMAN, aged 84 years, a medical practitioner without diplomas, but registered by the Victorian Medical Board, who was found in a destitute condition, covered up by some old rags, in an old hut in the bush near Cheltenham, was admitted to the Melbourne Benevolent Asylum on July 21.

JOHN WALTER PHILLIPS, M.B. Melb., 1873, L. et L. Mid. R.C.S. Edin., 1876, died at his residence, 30 Stanley-street, West Melbourne, on July 9, at the age of 39; the deceased gentleman was formerly Surgeon Superintendent in the New Zealand Government Emigration Service.

DR. J. T. CHAPMAN has commenced practice at Drysdale, 57 miles S.W. of Melbourne.

DR. G. T. HOWARD, late Resident Surgeon at the Melbourne Hospital, has commenced practice at 226 Nicholson-street, North Fitzroy, a suburb of Melbourne.

DR. HY. NICHOL has commenced practice at Bendoc, 310 miles S.E. of Melbourne.

WESTERN AUSTRALIA.

DRS. A. R. WAYLEN, T. Frizell, and F. Tratman have been appointed Justices of the Peace.

 PROCEEDINGS OF COLONIAL MEDICAL
BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards :—

NEW SOUTH WALES.

- Wiley, Thomas Ormsby, L.R.C.P. Edin., 1879; L.R.C.S. Edin., 1879.
 Lloyd, Henry Sanderson, M.B. Edin., 1883; C.M. Edin., 1883; M.R.C.S. Eng., 1883.
 Peel, Robert, L.K.Q.C.P. Irel., 1879; M.R.C.S. Eng., 1881.
 Mc'Neill, John Patrick, M.B., 1878; M.D., 1878, Trin. Coll., Dub.; L. et L. Mid. R.C.S. Irel., 1878.
 Patrick, Charles Adam, M.B. et M.S. Glas., 1877.
 Robinson, Archibald Clarke, M.D. Q. Univ. Irel., 1881; L.R.C.S. Edin., 1882.
 Swinson, George Newton, M.R.C.S. Eng., 1885; L.R.C.P. Edin., 1886.
 Pope, Henry Alexander Leptaria, M.R.C.S. Eng., 1886; L.S.A. Lond., 1886.
 Browne, John Martin, L.R.C.P. & S. Edin., 1870.
 Watson, Arthur, M.B. et M.S., 1874, M.D., 1879, Edin.
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QUEENSLAND.

Humphry, Ernest, M.R.C.S. Eng.

SOUTH AUSTRALIA.

- Barker, Walter Herbert, M.R.C.S.E., 1875; L.R.C.P. Edin., 1880.
 Langhorne, Thomas Grant, M.R.C.S. Eng., 1886; L.R.C.P. Edin., 1880.
 Woods, George, L.R.C.S. Irel., L. et L. Mid. K.Q.C.P. Irel., 1886.
 Holmes, Nathaniel Wheatcroft, L.R.C.P. & R.C.S. Edin., 1878.
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VICTORIA.

- Mackenzie, John Hugh, L. et L. Mid. R.C.S. Edin., 1880.
 Nichol, Henry, M.R.C.S. Eng., 1889; L.R.C.P. Edin., 1880.
 Young, William Edward, L.R.C.P. & R.C.S. Edin., 1871.

Additional qualifications registered :—

- Barrett, James William, M., 1884, F., 1887, R.C.S. Eng.
 Le Fevre, George, M.D. Melb., 1883.
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STATISTICS issued by the New York Cremation Society show that cremation is increasing in popularity in the United States. From the 4th of December, 1885, to the 30th of March, 1887, 100 bodies were incinerated on Long Island. Cremation Societies now exist at La Crosse, Wis.; Springfield, Ill.; San Antonio, Texas; Washington, Penn.; Lancaster, Penn.; and Pittsburgh, Penn. The United States Cremation Company claims that it has reduced more persons to ashes within a given space of time than any other Society in the world, excepting that of Italy.

MR. THOS. LAKEMAN, of 34 Pitt-street North, Sydney, offers for sale a STATHAM'S ECONOMIC LABORATORY (almost new, cheap). This contains requisites for the performance of complete courses of lectures, and for the various operations of qualitative analysis and chemical research.

MR. L. BRUCK, of 35 Castlereagh-street, Sydney, desires us to draw the attention of our readers to his immense stock of all requisites for Microscopical Work, such as slides, cover-glasses, mounting materials and mounting fluids, cabinets, &c. Mr. Bruck keeps also on hand a large collection of mounted pathological and physiological objects.

 MEDICAL APPOINTMENTS.

- Barker, Walter Herbert, M.R.C.S.E., to be Public Vaccinator at Mintaro, S.A.
 Bowe, Arthur, M.R.C.S.E., L.R.C.P. Edin., to be Public Vaccinator at Ararat, Vic., vice Dr. J. C. Weld, resigned.
 Branting, Karl Gustaf Teodor, M.D., to be Honorary Surgeon of the Woodville Rifle Volunteers, N.Z.
 Colpe, Johannes Christoph Ludwig, M.D., to be Government Medical Officer and Vaccinator for the District of Nymagee, N.S.W.
 Cooke, James, M.D., L.R.C.S. Edin., to be Public Vaccinator for the Christchurch District, N.Z.
 Geoghegan, Francis Meagher, M.D. et Ch. M. Qu. Univ. Irel., to be a Surgeon in the Queensland Defence Force.
 Holmes, Nathaniel Wheatcroft, L.R.C.P. & R.C.S. Edin., to be Public Vaccinator at Kingston, S.A.
 Humphry, Ernest, M.R.C.S.E., to be Acting Health and Medical Officer at Mackay, Qu., during the absence (on leave) of the Health and Medical Officer.
 Langhorne, Thomas Grant, M.R.C.S. Eng., L.R.C.P. Edin., to be Public Vaccinator in South Australia.
 McCall, Robert, L.R.C.P. & R.C.S. Edin., to be Health Officer for shire of Chiltern, Vic., vice Dr. F. Haley, resigned.
 Macnaught, John, L.R.C.P. & R.C.S. Edin., to be Health Officer for shire of Winchelsea, Vic.
 Mickle, Adam Frederick John, M.D. et Ch. M. Aberd., L.R.C.P. & R.C.S. Edin., to be Public Vaccinator for the district of Christchurch, N.Z.
 O'Neill, Gregory John Lamb, M.B. et Ch. M. Edin., appointed an Honorary Physician to St. Vincent's Hospital, Sydney.
 Reid, George Marr, M.B. et Ch. M. Aberd., to be Health Officer for shire of Winchelsea, Vic.
 Richardson, Arthur, M.D., M.R.C.S.E., L.R.C.P. Edin., to be Government Medical Officer at Glenelg, S.A.
 Scantlebury, George James, L.R.C.P. & R.C.S. Edin., L.F.P.S. Glas., to be Health Officer for shire of Grenville, Vic.
 Smeal, James, L.F.P.S. Glas., to be Health Officer for Ararat, Vic.
 Taaffe, Oliver Grenville, L.R.C.P. & R.C.S. Edin., to be Surgeon in the Victorian Mounted Rifles.
 Violette, William Bradley, M.B. et Ch. M. Glas., to be Visiting Surgeon to H. M. Gaol, Government Medical Officer and Vaccinator for the Parramatta District, N.S.W., vice Dr. Rowling, resigned.
 Wilkinson, Arthur Mackenzie, M.B. Melb., to be Health Officer for shires of Flinders and Kangeroong, Vic., vice Dr. T. Horr.
 Wilkinson, John Francis, M.B. et Ch. B. Melb., to be Public Vaccinator at Bright, Vic., vice Dr. G. F. Wickens, resigned.
 Woods, George, L.K.Q.C.P. Irel., L.R.C.S.I., to be Public Vaccinator in South Australia.
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PUBLICATIONS RECEIVED.

Manual of Bacteriology. By Edgar M. Crookshank, M.B. Lond., F.R.M.S., Demonstrator of Physiology, King's College, London. 2nd edition, illustrated with coloured plates and wood engravings. London : H. K. Lewis, 1887.

Rents of Pastoral Holdings. Speeches delivered by Wm. M'Millan, Esq., M.P., and the Hon. T. Garrett, M.P. (Minister for Lands), on a motion by Mr. M'Millan, condemnatory of the raising recommended by the Local Land Boards, made in the Legislative Assembly on the 7th June, 1887. Sydney : Charles Potter, Government Printer, 1887.

Elements of Pharmacology. By Dr. Oswald Schmiedeberg, Professor of Pharmacology and Director of the Pharmacological Institute, University of Strassburg. Translated by Thomas Dixson, M.B., Lecturer on Materia Medica in the University of Sydney, N.S.W. Edinburgh : Young J. Pentland, 1887.

Elementary Microscopical Technology. A manual for Students of Microscopy. Part I. The Technical History of a Slide, from the crude materials to the finished mount. By Frank L. James, Ph. D., M.D., President St. Louis Society of Microscopists, St. Louis, Mo. St. Louis Medical and Surgical Journal Company, 1887.

On Lupus Erythematosus, or Bat's-wing Disease. By Balmanno Squire, M.B. Lond., Surgeon to the British Hospital for Diseases of the Skin. With coloured plates. London : J. & A. Churchill, 1887.

REPORTED MORTALITY FOR THE MONTH OF JUNE, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	344	145	39	..	..	2	1	1	2	19	10	10	14
Suburbs	200,000	878	280	107	..	2	12	..	11	4	30	14	11	17
NEW ZEALAND.														
Auckland	35,965	97	30	12	..	2	2	..	1	3	..	3	4	1
Christchurch ..	15,684	47	17	..	..	1	..	..	2	3	..	..	..	..
Dunedin	24,233	58	12	1	..	1	..	..	..	1	..	2	..	..
Wellington	26,956	71	29	8	..	2	..	..	3	1	3	4	1	..
QUEENSLAND.														
Brisbane	32,571	122	35	15	..	..	9	1	4	7	1	7	3	2
Suburbs	41,082	179	51	11	{	..	..	..	..	..	..	..	..	..
SOUTH AUSTRALIA.....	307,989	977	312	104	..	..	12	3	8	9	24	22	10	20
Adelaide	42,904	125	61	16	..	..	3	..	3	2	9	4	2	1
TASMANIA.														
Hobart	31,005	99	31	11	..	..	3	..	6	..	3	4	2	4
Launceston	19,387	62	27	11	..	..	1	..	2	1	5	5	2	2
Hospitals, Asylums, Gaols, &c. .	1,283	...	51	..	..	..	..	..	..	..	..	..	..	..
Country Districts.....	88,590	246	65	..	..	..	4	..	2	2	..	..	..	..
VICTORIA.														
Melbourne	69,774	172	92	{ 189	..	..	15	4	15	7	73	56	39	27
Suburbs	275,606	1,068	479	..	..	..	..	..	..	..	..	..	..	..

METEOROLOGICAL OBSERVATIONS FOR JUNE, 1887.

STATIONS.	THERMOMETER.						Mean Height of Barometer.	RAIN.			Mean Humidity.	
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Depth.	Days.		Inches.	Prevailing Wind.	..	W.	..
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	..	67·3	..	39·2	29·898	..	..	..	..	..	79	..
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	115	64·5	54·6	39·	..	6·820	25	..	..	..	..	..
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.....	127	75·	56·3	41·9	30·011	0·168	5	..	..	..	65	..
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	107	56·	44·5	25·	..	5·983	20	..	..	..	..	..
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	..	..	..	..	..	..	..	..	..	..	84	..
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	..	63·8	46·6	30·5	29·915	2·31	19	..	..	..	90	..
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	..	60·5	47·6	27·9	29·922	2·73	14	..	..	..	81	..
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.....	..	65·	49·3	33·1	29·891	3·04	19	..	..	..	..	..
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.....	..	66·4	53·1	42·6	29·955	5·58	15	..	..	..	79	..
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	110	64·3	49·3	35·	..	6·864	24	..	..	..	83	..

ORIGINAL ARTICLES.

MAR 18 1888

**A CASE OF ACUTE SUPPURATIVE
SYNOVITIS OF THE KNEE-JOINT
—RECOVERY WITH COMPLETE
MOVEMENT, AFTER ASPIRA-
TION, &c.**

By THOS. BAIN WHITTON, M.D., &c., SURGEON
OF THE REEFTON HOSPITAL, NEW ZEALAND.

Miss H., aged 16 years, a strong healthy girl, was admitted to the Hospital on April 13, 1886. She had been engaged in household work for the last 2 years; had never suffered from any illness, nor could she recollect of having received any injury to the knee-joint. On admission, the pulse was 130; temp., 101·5°, suffering from thirst, sleeplessness, &c., with a foul tongue; urine, a dark orange colour, neutral, no albumen or sugar, but an intense deposit of lithates. Her right knee was so swollen and painful that she could not bear it to be moved, having to be assisted to her bed. An attack of rheumatic fever being suspected, she was at once put on the soda salicylate treatment: grs. x every two hours; the joint being kept cool with the liq. Pb. diacet et Opii lotion.

After 2 days of this treatment, the temp. fell to normal, and the pulse to 100; the pain having become localised in the one joint—no pain or swelling in any other joint—and the swelling had assumed that appearance seen in synovitis, viz., a bulging on each side of the patella, which was pressed forward, with a distinct fluctuation felt across the joint, from side to side. The swelling and fluctuation extended upwards, along the outer side of the thigh, for a distance of 8 inches under the extensor muscles. The joint measures 25 in. in circumference, while the sound one is 14 inches.

Treatment.—On the 7th day after admission, the temp. again rose to 100°, she had several attacks of rigors; constant pain in the joint, preventing sleep; with night sweats, and loss of appetite, all these being indications of suppuration having taken place, which was confirmed by inserting the needle of a small aspirator along the outer side of the patella, and drawing off 4 ozs. of pus.

Next morning (April 20), 10 oz. of pus was evacuated by a large aspirator; the needle being inserted for fully 4 inches along the outer side of

the patella in an upward direction. The pus, which was healthy and odourless, was allowed to run, until the blood appeared mixed with it, when the needle was withdrawn, the site of the puncture closed with collodion, and the knee-joint encased in cotton wool and bandaged, being supported on a pillow covered with macintosh sheeting; no splints or other support were now, or at any subsequent time used in the treatment of the case.

April 21.—The joint has assumed its normal shape and size; temp., 98°, and pulse, 88. At this stage she was allowed 3 ounces of wine daily with beef-tea, soups, &c., and taking the following: Pot. iod. 3 j; syrup ferri bromid. 3 ij; tinct. lupuli 3 j; tinct. camp. co. 3 j; tinct. cinch. co. 3 j; and glycerine ad. 3 vj. cap. 3 ij t.i.d.

April 24.—The aspirator was again used, drawing off 10 oz. pus, since the joint was as full and tense as on the first occasion, with the recurrence of nocturnal pains, night sweats, &c. And again on three successive occasions was aspiration had recourse to, evacuating about the same quantity of pus, but only to refill again in about 3 days' time.

May 8.—A free incision, of two inches was made over the outer side of the patella, and a counter incision down into the muscles about 8 inches above it; this allowed 16 ozs. of pus to drain away. The cavity was then thoroughly syringed with a sol. of hyd. perch. (1-1000), and a red rubber drainage tube inserted, having been previously soaked in carbolic acid (1-20) and cut off short; the thigh and knee covered with a layer of carbolic gauze, absorbent cotton and a bandage. Next morning temp. was 99·2°, and pulse 112.

May 9-19.—The wound was daily syringed with the same lotion; the drainage tube was removed, washed in carbolic acid, shortened, and reinserted; the pus was never foul-smelling, and it flowed freely through both the upper and lower openings, daily lessening in quantity. An artificial eucalyptus sponge, enclosed in a pad of carbolic gauze, was daily bandaged over the wounds for 10 days. On the fifth day after the use of the mercuric lotion, a pustular rash appeared over both the tibial and the deltoid muscles of each arm, these pustules were surrounded by a rose coloured circle of two or three lines in diameter. No ptyalism or diarrhoea was observed. This rash, which was at first itchy, and then painful, gradually disappeared on using the lotion reduced to 1-6000.

May 15.—Passive motion was now commenced, as the joint was becoming very stiff; it was bent

forcibly every second day, increasing the angle each time, until she was able to walk about on it. The wine and ferri brom. mixture are still continued.

May 20.—After 10 days use of the drainage tube, it was removed from the lower sinus, from which only a slight watery discharge flowed. The tube being shortened to 4 inches, was retained for another 10 or 12 days, in the upper sinus. Iodoform bougies (gra. v) were inserted in the lower sinus, but they, in a few days, produced a local eczema around the orifice, and had to be discarded for a lotion of tinct. iodine (3 i to 3 vi warm water). This lotion was most effectual in causing the granulations to spring up in the abscess cavity which contracted rapidly, under the daily syringing.

June 1.—Maltine (3 i after dinner and tea) was substituted for the wine ; the ferri. brom. was discontinued ; she was able to sit upon a chair for some hours, and to get about the ward on crutches; passive motion had been so persistently adhered to, that she was now able to bend the leg freely.

June 18.—Syringing, bandages, gauze, &c., were now all dispensed with ; a weakness of the ligamentum patellæ, preventing full extension of the leg, was treated with the interrupted current for ten minutes daily.

June 20.—She is able to kneel equally well on both joints ; sinus healed with no contraction, &c., remaining ; both joints are now the same in size ; she has gained 4 lbs. during the past week, and can walk about the garden with but the slightest limp, caused by the relaxed ligaments, but which become stronger each day.

June 25.—Discharged.

Remarks.—1. This case of synovitis occurred without any wound or injury, which is exceptional.

2. The aspirator was useless in removing the pus, which re-accumulated again, with pain, tension, and hectic.

3. The success of free drainage, daily syringing and dressing, &c. The use of the hyd. perch. in suppurating wounds is an open question ; it requires caution in its use ; a sol. of 1-1000 is too strong for continuous use ; the rash can only be ascribed to it. Anyway, the pus never became offensive or "bacterious." The artificial sponge, though expensive, is very handy in such cases.

4. Iodoform, in my experience, is never suitable for a deep cavity or a sinus, it always produces a local eczema around the wound ; but for a dry dressing in superficial wounds it has no equal.

5. Next to the complete evacuation of pus in this case, I consider that the early use of passive motion, contributed mainly to a successful termination.

LANCE WOUND OF THE ABDOMEN—STRANGULATED HERNIA—OPERATION—RECOVERY.

READ BEFORE THE N. S. W. BRANCH B.M.A.
BY B. J. NEWMARCH, L.R.C.P. LOND.,
M.R.C.S.E., OF BOWRAL, N.S.W.

THE case I am about to relate is one which is not often met with in daily practice, and though I can offer nothing new and startling, I trust it may be of sufficient interest to bring before your notice.

J. E. O., aged 25 years, a remarkably well built and very muscular man, whilst practising tent-peggng, in view of some cavalry sports, on January 14th of this year, rode at the peg with the lance in the usual manner and missed it. This annoyed him, and he threw the weapon over the horse's head. It struck the ground on "the near side," and, rebounding, pierced his abdomen. His comrades, who watched him, state that the lance seemed to "stick in his inside," and that he forcibly dragged it out with his left hand and threw it away. I saw him very shortly afterwards. He was then being taken home, which, providentially, was close at hand. He rode home supported on horseback and I came on the scene when he was a few yards from the house. I mention this as I should have objected to the mode of his conveyance if I had been at hand before. On putting him to bed he seemed very faint, and almost pulseless. He spoke in a quiet, even voice, and said he was in great pain at the lower part of his abdomen. On stripping him, a small triangular wound with contused edges was observed, situated about two inches above, and one inch to the left of the root of the penis. There was some swelling, reaching up from the orifice of the wound towards the left, soft, and apparently composed of extravasated blood. A most careful examination was made of the wound and its neighbourhood. I introduced my little finger as far as possible and could detect no protrusion of the bowel, and hoped that the lance had not actually perforated the peritoneum. I was a little in doubt about the swelling, which, as I have stated, reached up towards the left of the wound, and to further satisfy myself, I carefully passed a blunt-pointed probe into the wound, and found it passed to the right, with an inclination upwards, and knowing how careful one should be, I was satisfied, without prosecuting my endeavours with an instrument which might, however carefully handled, be productive of harm. I got him to cough, and could detect no impulse in any position of the body. A catheter was passed, and about one ounce of clear pale urine withdrawn.

He vomited some undigested food almost

directly after going to bed. A pill of opium gr. was then given, and repeated in half-an-hour, and ordered to be continued every three hours if in pain, if not, every four hours. Liquid food in very small quantities. At 9 p.m. (about three hours after the injury) the pulse (84) was much stronger at the wrist. He expressed himself as much better. Temperature, 98° F.

Jan. 15.—Passed a fair night; free from all pain, though he felt stiff; had vomited almost everything taken. He stated that he was a very bilious subject. The vomit was green, almost odourless, and apparently consisted of the liquid food he had taken and bile. A bismuth and morphia mixture was given every four hours, and the pills continued. The pulse was strong and full (76); temperature, normal; tongue, dark and foul; the breath smelt very strong and foul. The wound appeared healthy, and the dressings—iodoform and cotton wool—were re-applied.

Jan. 16.—Passed a more restless night; vomited in the morning after the bismuth mixture, after that he kept down small quantities of broth; temperature and pulse normal; no tenderness of belly; no dulness in the flanks; wound healthy, and closing rapidly; no discharge; the bowels have not been moved; complains of sick feeling after taking food.

Jan. 17.—Good night; pulse, strong and full; temperature, normal; abdomen, natural. 10 a.m.—Administered an injection of half-pint of olive oil, followed by half-a-pint of warm soap and water; no action followed. Injection repeated at 3.30 p.m.; about $\frac{1}{2}$ -pint retained. Injection repeated at 5.30 p.m., about one pint and a-half; a slight action followed. At about 6 p.m. he vomited a large quantity of bilious matter. The opium pills have been left off.

Jan. 18.—No vomiting the whole day; given small doses of morphia with drop doses of vin. ipecac. every quarter of an hour for two hours, afterwards every two hours; mustard poultice applied to epigastrium; small quantities of fluid nourishment taken; small motion passed.

Jan. 19.—Feels much better; passed a free motion, and afterwards another smaller one; at 6 p.m., vomited again, bilious, stinking matter; pil. opii. to be repeated every six hours.

Jan. 20.—No vomiting since last note; expressed himself as quite well, and wanted to get up; no pain or tenderness anywhere over the abdomen; I noticed dulness in the flanks, better marked on turning him over on the sides. He would have it that he was simply suffering from a bilious attack, similar to many he had had before, and begged me to let him have some Eno's Fruit Salt. He took about one teaspoonful in a little water, and followed it by half a cupful of warm tea.

Directly he had taken it he vomited half a large chamberful of brown grumous vomit, which smelt of faeces. I had not seen the vomit of the previous evening, but, from what his attendants told me, I have little doubt but that it was composed of the same material. I ordered him to take nothing by the mouth, and administered nutritive injections. On examination of the wound a gurgle was felt under the finger. 12 (mid-day).—No change, and expresses himself as quite well. 7.30 p.m.—Consulted with Drs. Scot-Skirving and MacCormick, who both carefully examined him. Dr. Skirving distinctly felt, as I had previously, a gurgle under the fingers on examination of the wound, which could not be repeated. We all decided that there probably had been a knuckle of intestine, or piece of omentum, nipped in the region of wound, and that, most probably, it had been reduced during the examination in the morning, and again, perhaps, during Dr. Skirving's manipulation. Temperature, 98.8; pulse, 72, full and strong; tongue, moist, and fairly clean. No vomiting since 10 a.m.

Jan. 21, 7.45 a.m.—Saw patient again with Drs. Skirving and MacCormick. He had passed a comfortable night, free from pain; no vomiting; temperature, normal; pulse, 78, strong; bowels had not acted; no tenderness, or even feeling of illness. It was agreed that the remission of the dangerous symptoms did not warrant any operation. 2 p.m.—Vomited again, distinctly faecal. I decided to cut down and examine the region of the wound. This I did, with the assistance of Drs. Morgan and Lambert, at 5.30 p.m. An incision was made from $\frac{1}{4}$ -inch below the orifice of the wound, reaching upwards and slightly outwards, for about 3 inches. Layer by layer of tissue was cut down upon and through with the knife and director. The colour and appearance of the structures in the neighbourhood of the wound occasioned some anxiety. At length a knuckle of intestine was reached, which looked very discoloured, in fact, dark brown. A portion, fully one inch in length, was protruding through a slit-like opening, apparently having the rectus tendon for its inner border, and the conjoined tendon for its outer boundary. The finger introduced could well detect the sharp-sided opening. The gut was distinctly adherent to the inner side. On passing the finger carefully round the inner side the adhesions were separated, and the gut returned. The finger was then carefully introduced through the opening, and the gut felt fully reduced. A large Wood's hernia needle was passed through the two borders of the wound, carefully guided and guarded by the finger, and threaded with a double strand of No. 3 catgut. On tying

this the borders were brought together, a drainage tube introduced through the lower aperture, and the surface wound stitched together with sulphurous catgut. After being put to bed he again vomited a quantity of faecal-smelling matter. He recovered well from chloroform. Temperature, 9 p.m., normal; pulse, 86. He made an uninterrupted recovery, and was allowed to get up in about 14 days. The wound was carefully guarded by a celluloid truss.

Everything went very well until February 17, when he developed symptoms of orchitis in the left testicle, and had a pretty smart attack, but in a few days recovered, and was up and about again very quickly.

Remarks.—The case is chiefly of interest as representing a not uncommon, but important class of cases, viz., strangulated hernia, with masked symptoms. I have little, if any, doubt but that the bowel was strangulated from the very first; and this is borne out by the fact that considerable adhesions were found at the time of the operation. The points worthy of especial notice are:—(1) Absolute absence of all symptoms of prostration; (2) absence of all pain or tenderness; (3) remission of the vomiting, on one occasion for over 48 hours, on another for 30 hours. Prostration is a marked symptom in cases of strangulated hernia, and so important that in epidemics of cholera the two have been mistaken, and French authors have designated that form of cholera accompanied by severe collapse "cholera herniare" (Heath's Dictionary). At no period, except for the first half-hour immediately following the infliction of the wound, did the patient even feel ill, and with difficulty could I persuade him to keep to his bed. The absence of the other symptoms might be explained by the frequent and almost continual exhibition of opiates, though I have on one occasion met with a case which illustrated the total absence of symptoms perhaps more forcibly. The subject was a night nurse in the Ipswich Hospital, England. She applied to me one morning when called up to see a patient, for relief for continual vomiting after food. On examination, I discovered an acutely strangulated femoral hernia, which was immediately operated on. It was acutely inflamed. Pus had already begun to be formed in the neighbourhood, and the gut was in a sphacelated condition, and utterly beyond redemption. She had been suffering for some days, but never complained of pain, or even drew attention to the *ruptus*, which was discovered by accident. If I were to meet with another case of abdominal wound, I would not hesitate to boldly cut down and explore the wound, and if symptoms occurred which could not be readily explained, then perform laparotomy.

PUERPERAL ECLAMPSIA, TREATED BY HYPODERMIC INJECTIONS OF NITRATE OF PILOCARPINE.

READ BEFORE THE S. A. BRANCH, B.M.A.

BY J. H. S. FINNIS, M.B. ET C.M., EDIN.,
OF COLLEGE TOWN, ADELAIDE, S.A.

Mrs. E. R. S., of Stepney, æt. 24 years, was delivered on the 18th inst. of her fourth child, at 6 p.m. She had an excellent confinement. At 2 p.m. on the following day I was sent for, as she had been suffering since the morning from severe cephalgia. She complained of a pain of a throbbing nature, and seemed to be in great agony. Her pupils were somewhat dilated; temp., normal; pulse, 96 per minute. I prescribed for her and left the house.

At 7.30 p.m. on the same day, her husband came for me, stating that she had had two fits since I had left her, one at 3 p.m., or half an hour after my departure, and the second at 7 p.m. I found her rather excited, complaining much of her head. Her pupils were fully dilated; pulse hard and wiry. She was then quite sensible, and whilst conversing with me she was suddenly seized with a violent epileptiform convulsion; first a tonic spasm of the whole body, succeeded almost immediately by clonic contractions, the muscles of the face twitching violently; the globes of the eyes turned up, so as to leave the white sclerotics alone visible; face and lips deeply cyanosed; frothy saliva tinged with blood issuing from the lips; teeth firmly clenched. These contractions soon passed downwards and involved the whole muscular system. These lasted 3 or 4 minutes, and were followed by stertorous breathing, which lasted about 10 minutes longer. During the fit I gave her ether. I prescribed 20 grains of chloral and 25 grains of bromide of potassium every 2 hours, until sleep was induced. As she seemed then quieter, I left the house. At 2 o'clock the next morning, her husband called me up, and said that his wife was very bad again, having had five fits since I last saw her. She had then taken 60 grains of chloral and 75 of potassium bromide. I ordered one or two more doses of the same mixture, with the addition of valerian, ice to the head, sinapisms to the calves and soles of the feet, a dose of calomel and jalap, and a purgative enema pending the action of the purge. The enema produced a copious motion. At 6 a.m. I was again sent for, as, although she had had five doses of the chloral and bromide mixture since the preceding evening, and her bowels had been freely opened, the convulsions were recurring about four or five times in one hour. On my

arrival I found her much exhausted, pulse weak and quick, temperature 101 deg., pupils dilated, and quite unconscious. A convulsion came on soon, and I again gave her ether, whilst waiting for some nitrate of pilocarpine, which I had sent for.

I was induced to try the latter from having read in the *Lancet* of May 29, 1887, about several similar cases treated successfully with hypodermic injection of pilocarpine, by Dr. Murphy, of the Durham University.

At 7 a.m. I injected $\frac{1}{2}$ of a grain. Within a minute or two profuse perspiration came on, and saliva poured out of her mouth; pupils contracted a little. She had five more convulsions, with stertorous breathing in the intervals, up to 8 a.m., when I injected another $\frac{1}{2}$ grain. She had had three more convulsions up to 9 o'clock, but these were milder and shorter. During each fit I administered ether to assist in lessening arterial tension. As she appeared easier, at 9 a.m. I left her.

At 3 p.m. I was again sent for. It appears that she slept calmly for a couple of hours after my departure, but at 2 o'clock she had a convolution, another at 2.30 p.m., and a third in my presence. This last appeared to me to be worse than any of the preceding. I at once injected $\frac{1}{2}$ gr. of nit. of pilocarpine, which produced the same physiological action as in the morning, and as she seemed easier, I left her.

At 8 p.m. I called. She had slept for three hours, but was very restless, and tossing about a good deal; temp., 104.2 deg.; still unconscious, but takes beef-tea and milk; passes urine and her motions in bed; has had no more convulsions since the third injection.

At 7 o'clock the next morning (21st inst.) her temperature was 103 deg.; has had no return of the convulsions; has slept at intervals through the night, but is still unconscious. At 8 p.m. of the same day, temp., 98.2 deg.; had a good calm sleep for three hours in the afternoon. Has had plenty of milk during the day, which she swallowed mechanically.

22nd.—At 9 a.m., temp., 99 deg.; had a fair night, and was conscious, for the first time, this morning—has been unconscious, therefore, about sixty hours altogether. She answered only in monosyllables, seems dazed, and does not remember anything that has happened, and was surprised when she was shown her baby. From that time she has progressed favourably, although her memory remains weak, and at times she does not know those about her.

I have thought this case worthy of being recorded from its severity; the lengthened period of unconsciousness; the fact that the convulsions

only commenced 21 hours after the delivery; resisted all ordinary treatment, but were combated by the pilocarpine. Although they did not stop after the first injection, I am inclined to believe that this was due to the dose not being large enough. I did not have recourse to bleeding, as the patient is very anaemic, and I did not consider that it would be of benefit to her, but quite the reverse.

The patient is of a very nervous temperament, and at the age of 14 suffered from a severe sun-stroke, whilst riding in the sun on a very hot day, near Mount Gambier. She was confined of her first child at the age of 16 $\frac{1}{2}$. I only examined her urine on the second day, and found a trace of albumen.

This is the third case of puerperal eclampsia which I have treated. The first two occurred in my practice in Mauritius some years ago, but took place during pregnancy, and were arrested after delivery.

Discussion.

Mr. Giles stated that in 1881 he saw a case of puerperal eclampsia treated, in the Edinburgh Maternity Hospital, with nitrate of pilocarpine, by Dr. Halliday Croon, with most excellent results. The general dropsy was intense, and albumen present in the urine in great quantity. Soon after the birth of the child the convulsions commenced, the patient being perfectly unconscious, and the breathing stertorous. On the morning of the third day injections hypodermically of $\frac{1}{2}$ gr. of nitrate of pilocarpine were employed, with rapid and very satisfactory effect.

Shortly after commencing practice in Adelaide he had such another case coming on after labour, which yielded rapidly to injections of $\frac{1}{2}$ gr. of nitrate of pilocarpine, used every two hours for one day. In his case the patient was unconscious about 48 hours, and he commenced injections on the second day, after trying other remedies with no benefit. It is interesting to notice how rapidly this dose brings about the physiological action of the drug. Within a minute after the injection, drops of perspiration were running off her forehead, which previously was quite dry. After the first injection the frequency of the convulsions diminished; and by evening consciousness returned.

Dr. Lendon alluded to a case which occurred on board the emigrant ship "Oriana," on her passage out to Adelaide. The patient, wt. 19, had been delivered of a child only twelve months previously, without any complication; this time, however, labour set in at midnight, and proceeded very slowly; at 8 a.m. convulsions occurred, followed by a status epilepticus, every disturbance

and attempt at examination inducing a fit, after which she relapsed into unconsciousness. Having no Barnes' bag on board, it was necessary to wait until the os was dilated enough to allow forceps to be used. The convulsions continued for 16 hours after delivery, lasting altogether 24 hours. During the next day the patient improved, and on the day after was quite rational again. Each fit appeared to be modified in severity by administering chloroform. There was no reason for suspecting renal disease, and the patient had enjoyed good health throughout the voyage.

Mr. Finniss remarked that from his experience of two of the cases of puerperal eclampsia which he attended, he did not consider albuminuria an essential cause of such, as it was absent in those two cases. He attached more importance to severe and persistent cephalgia recurring in pregnant women, or soon after parturition, as a forerunner of eclampsia.

PLEURITIS WITH EFFUSION—ENTRY OF PUS INTO SPINAL CANAL—DEATH.

By J. C. VERCO, M.D. LOND., HON. PHYSICIAN
ADELAIDE HOSPITAL; LECTURER ON MEDICINE, UNIVERSITY OF ADELAIDE.

Mrs. P., *æt. 48*, on March 5, after being at her housework all day, went to Glenelg at 7 p.m. for a change, because of the heat of the weather, but found it so hot there, that she returned home by the next train. The same night she was taken ill with chills and feverishness, and a pain in her back.

Was seen two days after. The pain complained of was under the right shoulder-blade—as she said, “neither outside her chest, nor inside her chest.” The arm could be moved without pain; there was smart pyrexia with rapid pulse, and slightly increased rapidity of respiration; nothing definite was discovered in the chest; there was a little crepitant sound in the right lateral and posterior base.

I expected a development of the signs of pleuro-pneumonia, but she only had a patch of herpes on the right half of the lower lip, and an obscure impairment of resonance over the right back, between the spine and the base of the scapula, and a little below the angle, without decided alteration of the normal auscultatory signs.

On March 14 her fever had considerably subsided, but yet she did not either develop definite chest trouble, nor improve satisfactorily, and the original diagnosis of pleurisy was wavering in

favour of enteric fever. On this day, she was much troubled with frequent micturition, and had repeatedly to rise to urinate.

March 15.—Was able to get out of her bed and stand up while it was being made, but her legs felt very weak.

March 16.—Last night she had most profuse perspirations; had not passed water since 4 p.m. yesterday, so at my visit at 9 a.m. she was catheterized. Her legs felt weak, but she was able to move them about in bed. P. 84, regular; T. 99.4; moaning with pain in the legs, especially at the knees and ankles.

March 17.—P. 92, R. 84, T. 98.4. Can only move right great toe, no other part from hips downward; sensation present; diminution questionable; superficial reflexes present, but diminished, so also the plantar; abdomien puffed; abdominal muscles act in respiration; and voluntarily during catheterism.

March 18.—All movement of the toes paralysed. In the evening distinct diminution of sensation in the legs.

March 19.—Right pupil rather larger than the left, but both re-act well. Sensation perceptible in the left leg, but lost in the right to about the middle of the shin, except on the sole, and a point on the front of the shin about the top of the lower third; diminution above that, up to the right breast; sensation of heat lost below the groin; muscles re-act to faradism, but less in the right leg than the left. Bed-sore forming on right buttock; much pain from right shoulder to the navel.

March 22.—Sensation lost up to level of right nipple, and two inches below left nipple; touch in arms and hands perfect; mind clear.

March 23.—Anæsthesia up to left nipple, and two inches above the right; still slight reflex in the soles; urine ammoniacal and bloody; throat feels dry; feels afraid to go to sleep, lest she should choke.

March 24.—Had rigor at 6 a.m., beginning in the chin and affecting the arms, lasting quarter of an-hour.

March 25.—Lied at 8.30 a.m.; conscious till quarter-hour before death.

The temp. was almost always raised above the normal, varying irregularly to 101.6; pulse from 84 to 120; never any irregularity.

There was retention of urine from March 16 till death; the bowels were most obstinately constipated till March 21, then, by somewhat severe purges and several enemata, they were moved, and were inclined to be loose until she died.

A section was made about an hour after death. There were three large superficial bedsores on the nates and the lower part of the sacrum, and a

smaller one on the left chest below the angle of the scapula. An obscure fulness was palpable between the scapulae, and an indistinct sense of deep fluctuation on each side of the spine. On cutting down to expose the spinal arches, pus was found in small quantity between and beneath the spinal muscles. This, on the left side, did not extend quite so far outwards as the base of the scapula, but, on the right side, it passed a little distance under this bone. It was found to well up from between some of the arches of the vertebrae; and there were also two bare places on two of the right ribs, about an inch from the transverse processes. At these spots the finger could be passed into the right pleural cavity, and, on opening this up, a circumscribed collection of pus was discovered, over an area of the size of one's hand, lying behind the lung.

On opening the spinal canal, there was found a circumscribed collection of pus, limited definitely above and below, to an area from 3 to 4 inches in extent.

The pus lay on the outside of the dura-mater, which seemed to be quite healthy, except that there were two or three little yellowish-white patches of thickening where bathed by the pus. There was no pus inside the arachnoid. Here the cord, to the naked eye, seemed slightly thicker, and felt a little softer than lower down. The spinal canal appeared smooth and healthy throughout, and showed no signs of caries; but on the right side, just about the centre of the purulent collection, was a hole, allowing of the admission of a probe, apparently through an intervertebral foramen, by which the spinal cavity communicated with the circumscribed empyema.

The sequence of events, pathologically, was probably as follows:—

First, an acute pleurisy, with circumscribed purulent effusion in no great quantity, on the right side, beneath the right scapula and the right interscapular space; perforation of the parietal pleura, with destructive periostitis over a limited area on two of the ribs; travelling of pus along an intercostal nerve into the spinal canal, and so compression of the cord, and burrowing of pus beneath and among the erector spinae muscles. I imagine it is needless to say that the exact progress of the disease was not recognised during life. There was a diagnosis of pleurisy in the first instance, the evidences of which were never satisfactory. There was a diagnosis of acute myelitis of a nondescript character afterwards. The certainty of the spinal disease, overshadowed, and further discounted the uncertain diagnosis of pleurisy, so that the connection was not even guessed. The case teaches the oft-taught but hardly-learned lesson, that disease, however com-

plicated, is attended by symptoms, which, if properly interpreted, would reveal the disease to the observer; and were the symptoms read consecutively, as they ought to be, the sequence of events in the progress of disease, would often be manifest to our own satisfaction, and sometimes to the greater benefit of the patient.

TREATMENT OF CERTAIN FORMS OF CHRONIC ALCOHOLISM.

(READ BEFORE THE QUEENSLAND MEDICAL SOCIETY ON JULY 12, 1887.)

By J. H. LITTLE, M.B. ET CH.M., EDIN.

ALCOHOLISM, the subject I wish to say something about this evening, is one that we are all so thoroughly familiar with, that I have no intention of discussing it generally; but, having drawn your attention to the peculiar forms of this trouble which we have to deal with in the colonies, to ask your very serious consideration of the final proposal I have to lay before this society as to the necessity there is for some change in our law to enable us to deal effectually with a certain form of this disease.

There are four classes of the community who injure themselves by the excessive use of stimulants. In the first place, there are the men who pass their lives in the bush, away from all society, leading lonely and terribly monotonous lives, and eating the same food day after day, and week after week—salt-meat and damper, or mutton and damper, no vegetables, and only drinking water or tea with each meal. These men come down into town, and almost always go on the spree for days or weeks at a time, and most probably are very ill indeed before they stop their carouse. If they have fair play in the quality of the drink they partake of, and do not break their necks exhibiting to admiring onlookers their horsemanship, they give little trouble and less fees to either medical man or undertaker, and seriously, I have often thought this wild outburst of excess may relieve them to some extent from the consequences of their monotonous lives—anyhow they go back content to resume the dreary routine, looking forward with hope to a glorious future.

Belonging to another class is the man who drinks frequently, and at all times in the day, not getting drunk, perhaps conducting his business to his own satisfaction and benefit, but whose clients prefer to see him on important business in the early morning if possible. This man is not a

nuisance by any means, sometimes the reverse, an agreeable, kind-hearted good fellow, but undoubtedly laying up trouble for himself in the future, in the shape of liver, kidney, heart or brain lesions, a dangerous life for insurance companies, but often at first, suffering only from gastric catarrh or haemorrhoids.

There is a third class, comprised of young men who drink more from moral weakness. They drink because others drink and ask them to drink with them—they are too indolent or careless about it to refuse. They are always dropping into an hotel with a friend, and unfit themselves, by excess, for serious work, and undoubtedly injure their constitutions. They could, however, control their libations easily if they would, and the injury being to themselves alone, so also is the remedy in their own power.

There remains, however, another class to which I wish to draw your *particular* attention. It is where a man, without any previous warning, having perhaps rather disliked stimulants, very often being a rigid teetotaller, breaks out suddenly into a furious drinking bout, which he will continue until he is either restrained, or the intense desire for drink has exhausted itself. He will then resume his former regular, sober life; generally so far from wishing for stimulants, perfectly loathing the sight of them, and without the slightest danger of breaking out again until the peculiar brain-condition returns, when he is just as bad as ever, and becomes the despair of temperance societies, as he was before the most edifying example of their power. As the outbreaks become lengthened, the intervals become shortened, until morally, socially, and financially he is a wreck. These cases are by no means uncommon, and when the disease occurs in a woman, the results are, if possible, more disastrous, especially if she is the mother of a family, and, as too frequently happens, she belongs to the better class of society. These are not criminals, but people suffering from a disease well-termed dipsomania, probably caused by some hereditary taint. They are not morally responsible for their outbreaks, for, although in other respects, and at other times, conforming to all the accepted rules of society, when the attack begins, neither strong religious feeling, social connections, business responsibilities, nor family claims have the slightest power to restrain them from making beasts of themselves. Anything more striking than the difference between their appearance when suffering from the attack, and that presented by them before and after, can only be imagined by those familiar with attacks of acute mania. At the beginning there is often little difficulty in treating these cases, from the fact that you can control

their supply of drink either by strong moral suasion, or by their friends persistently refusing to allow them any indulgence. Unfortunately, as attack follows attack, they will not be controlled, and the cunning and determination exhibited by them in getting their craving satisfied is marvellous. So long as we can prevent their getting drink, we can easily relieve the very serious symptoms which may accompany the attack—such as sleeplessness, and nervousness, by bromide of ammonia, or bromide of potassium, or perhaps more effectually still by the subcutaneous injection of morphia,—persistent vomiting by calomel, followed by ammonia in effervescence. But, so long as they get stimulants, we are helpless, and the position of a medical attendant under such circumstances is both mortifying and undignified.

Now, my proposal is that the State should give someone authority to control these people, and prevent them from not only ruining themselves, but dragging down others who may be dependent upon them into destitution and misery. That such power is necessary, from my own individual experience, I feel certain, and if I considered it advisable, could detail numerous cases from my own practice, in which a fatal termination took place, which might easily have been prevented, had such authority existed. I would suggest that on an information being laid before a magistrate by an intimate friend or relative, and supported by the certificate of two medical men, such a man or woman should be confined in an Inebriate Refuge, and detained there for such time as is deemed necessary for his or her permanent cure. For a poorer class of patient, a suitable place might be provided on an island in Moreton Bay, such as Dunwich, for instance, where a medical superintendent is already stationed. A more luxurious home would soon be provided by private enterprise, for such patients as were in a position to pay for extra accommodation. The State Refuge should be made almost, if not entirely self-supporting, by the enforced labour of the inmates, which should be of such a nature as to fit them for earning a livelihood after leaving the institution, while promoting their return to a healthier condition. The good results that would ensue from judicious treatment in such institutions would well compensate for the slight expenditure necessary in the number of valuable lives spared to the State, and for one life saved by actual treatment in the institution, I think I am not over estimating it when I say that twenty would be stopped at the outset by the knowledge that power to place them under such salutary restraint existed, and would undoubtedly be exercised by their friends.

A SUGGESTION WHY PNEUMONIA AND PHthisis USUALLY SELECT DIFFERENT AND DEFINITE LOCALITIES IN THE LUNG FOR THEIR ORIGIN.

By G. L. L. LAWSON, L.R.C.P. EDIN., M.R.C.S. ENG., MEDICAL OFFICER, BALRANALD HOSPITAL, N. S. W.

IT is universally acknowledged that pneumonia and phthisis usually select certain definite parts of the lung for their commencement

The parts selected are generally the two extremes, viz.—the base and the apex, pneumonia selects the lower lobe, most often the base; according to Fagge, Jürgensen says it only escapes in one case out of four. Phthisis generally selects the apex

Let us take pneumonia first and ask why should it select the base? Some say it selects no particular situation. Bristowe suggest that as the lower part comprises about $\frac{1}{3}$ of the lung substance, the probability is that pneumonia would begin in some part of the base.

There are apparently sound physical reasons why the sites, base and apex, are respectively selected by these complaints. The lung is pyramidal, the apex rises above the first rib into the neck. The base extends almost as low as the last rib. The base, from its position, should be the least frequently attacked by inflammation, especially the posterior part, for to reach here, the external air has a long distance to traverse and has ample time to be raised to the required temperature. It is also protected by a thick layer of muscles. The vertical distance between apex and base in the adult is about twelve inches, more or less. The external atmosphere has equal access to both apex and base.

The sp. gr. of blood is 1055, therefore the difference between blood pressure from gravity on the capillaries of the base and those of the apex is about half-a-pound on each square inch of surface.

The difference in the counteracting pressure of the atmosphere is practically nil. The greater blood pressure on the base being counteracted by 1st—greater tone of the sympathetic and pneumogastric nerves, leading ultimately to—2nd—an increase in the strength of the parenchyma. Therefore, the greater blood pressure in the base is practically counteracted by increased nerve tension. From this it follows that if a susceptible person be exposed to a chill or cold prolonged enough to incite pneumonia, the nervous tone is

lost, the pulmonary branches of the sympathetic relax equally, the capillaries of base having to sustain a greater blood pressure than those of the apex are less able to withstand the increased rush of blood, consequently they dilate, their tone being lost and their resistance overcome they are unable to react, and then we have congestion of the base, perhaps proceeding to inflammation. As the lower part becomes congested and the passage of blood through it becomes impeded, the capillaries on a higher level are successively congested, thus it spreads upwards until the inflammation runs its course, or there is sufficient tone in the vaso-constrictors to prevent its further progress. The right base is more often attacked than the left. Fagge says "the right lung is more often the seat of inflammation than the left, the proportion being about five to three." Now the right apex extends higher than the left. The right lung as a whole is higher than the left, but at the back part of the base they are practically on the same level, therefore there is greater blood pressure on the right base, or the pressure being equal, the right base being larger than the left also accounts for it. Again, in hypostatic pneumonia supervening on other complaints, the most dependent part of the lung is attacked, because there is loss of tone in the vaso-constrictors and the blood pressure is greatest in the back, which, in this case, is the lowest part of the chest. Here I have spoken of pneumonia as an inflammation of the lungs, and have not discussed the origin of the inflammation, but simply the cause of its selecting a special site.

In phthisis the apex is primarily affected. It is not from any inability of this part of the lung to expand and receive its proper supply of air, otherwise we would find other corners and edges of the lung equally subject to phthisis. Dr. Fagge draws attention to the fact that women use the apices more than men, and that in them the apices are no less subject to phthisis, but then they do not use the apices more than other parts of the lung; and again, women as a rule, are confined more to the house than men, and breathe more impure air, which, irritating the part with which it comes in contact, counteracts the beneficial effects of exercise, and is one of the commonest causes of phthisis.

Tanner says the left apex is usually affected. The right apex is higher than the left, and the right should be oftener attacked; but here the beneficial effects of exercise are plainly demonstrated. The right area being exercised more than the left, and both lungs being equally subject, this continual exercise will more than fully counteract any slight predisposition there might otherwise be in the right apex.

No doubt in some men the vesicles in the apices do collapse, but not from inability of the air to fill them. The blood pressure here is less than in the base, the circulation flags, as a result of this the vesicles collapse, there is a diminution in the nerve force, blood pressure, and also in nourishment. The capillary walls not being so braced up, as it were, collapse, and are less able to withstand the attack of any debilitating complaint.

Dr. Fagge states—he has heard Dr. Moxon assert that in persons confined to bed the regions which become the earliest seats of tubercle are the anterior edges. In these cases the blood pressure is least in the anterior edges. In the base there is a greater blood pressure, this affords better nourishment and a greater amount of nerve tone.

In wild animals confined in cages as in the zoological gardens and menageries, phthisis is a common mode of death. According to this theory, phthisis in them ought to commence in the dorsal or back part of the lung, but beyond reading that phthisis is a mode of death, I have never heard in what part of the lung it originates.

One of the best modes of treatment is residence in an elevated district, and Jaccoud recommends an altitude of 4,000 or 5,000 feet, or even in some districts one as low as 1,650 feet. The altitude seems to depend very much on latitude, more so perhaps on the amount of moisture in the air, but in no case is it less than 1,650 feet above sea-level. The pressure of 1,650 feet of air nearest the earth will be slightly more than the pressure of twelve inches of a fluid of sp. gr. 1055.

This altitude of 1,650 feet, by withdrawal of atmospheric pressure, will throw an increased burden to the extent of about half-a-pound on each sq. inch on the capillaries of the lung, and will therefore be equivalent to an increase in blood pressure on the pulmonary capillaries of half-a-pound on each sq. inch, exerting on the apex a pressure equivalent to the ordinary pressure on the base at sea-level.

This increase is enough to make the apex as insusceptible as the base at sea-level, but in predisposed individuals it will only perhaps delay the outbreak, as the base is affected in the later stages, and is not proof against the invasion of phthisis, and it will require a still higher altitude to correct this inherent tendency.

This increased blood pressure, or rather decreased atmospheric resistance, will also be equally exerted on the base, but in this case it does not cause congestion because the sympathetic has not lost its tone, and is able to react and counteract the increased flow of blood.

This increase of blood pressure both on apex and base, especially the former, is first counter-

acted by increased nerve action, or tonicity, brought about by the stimulating effect of a pure dry air, which, through the agency of the vaso-constrictors, contracts the capillaries. This being continued for months, the parenchyma and capillary walls at length partake in the general reaction, becoming stronger, firmer, and better able of themselves to resist degenerative changes. Owing to the rarefied air, the respiratory muscles acting more energetically, expand the chest more thoroughly, the lung and the remote air cells are dilated and air gets to every part. The beneficial effect of the climate of the inland plains of South America, and the Riverina, in Australia, the latter with an average annual rainfall of 14 inches, and an elevation of about 400 feet, renders the climate for a great part of the year practically devoid of moisture, may be similarly explained by the dry stimulating atmosphere, on account of the dryness the evaporation from the lungs is increased, this evaporation is cooling to the surface, giving tone to the vaso-constrictors.

Phthisis is never seen where mitral stenosis exists; here the blood is impeded or regurgitates, and is driven back into the pulmonary vein. To antagonise this there must be increased nerve tonicity and probably thickening of the coats of the vein. In these cases congestion and inflammation are of common occurrence. In aortic disease the patients are thin, pale, and ill-nourished; according to Traube they are exceedingly liable to phthisis. Here the blood propelled into the arteries recedes, causing a decrease in the blood pressure, there is likewise a decrease in pressure in the bronchial capillaries supplying the lung with nourishment, thus inducing degenerative change. The subjects of chronic bronchitis are seldom or never phthisical.

Asthmatic patients never die of phthisis, unless the asthma has previously left them; in these cases there is also increased blood pressure.

I have endeavoured to show that the locality of pneumonia and phthisis is fixed by the blood pressure. In support of this I repeat, that in persons following their ordinary avocation, phthisis commences in the apex, and pneumonia in the base. In persons confined to bed phthisis attacks the anterior edges, and pneumonia the posterior.

In these examples the highest part is relegated to phthisis, the lowest to pneumonia. Also persons suffering from "complaints which increase the blood pressure in the lungs are subject to congestion, etc., and not so liable to phthisis as those suffering from complaints lowering the blood pressure. There are several exceptions, e.g., pneumonia in children affecting the apices, and phthisis supervening on other complaints, e.g., pneumonia, etc., which do not invalidate the theory.

THE INTERCOLONIAL MEDICAL CONGRESS IN ADELAIDE.

THE first Intercolonial Medical Congress ever held in Australia was successfully inaugurated in Adelaide on Tuesday, August 30th. The members of the Congress, who numbered 155, included representatives from all the colonies excepting Tasmania and Western Australia. The majority of the members, as a matter of course, were practitioners residing in South Australia; 53 were from Adelaide and the suburbs, 36 from the country, and 1 from the Northern Territory. From Victoria there were 29 delegates, from New South Wales 23, from Queensland 8, from New Zealand 4, and from Fiji 1. The formal reception of members by the Mayor (Mr. E. T. Smith, M.P.) took place on Tuesday afternoon. Over 100 gentlemen, including delegates from the other colonies and friends, were entertained by His Worship at luncheon in the Town Hall Banqueting Room. A toast list was submitted, and in a suitable speech the Mayor welcomed the visitors, and expressed the desire of the citizens that the Congress should prove of benefit.

THE INAUGURATION OF THE CONGRESS.

The inaugural meeting of the Congress was held in the Councillors' Room. In addition to the members of the Congress there were also present a number of visitors, the room being well filled. His Excellency the Governor arrived at 3 o'clock, and was received and escorted to his seat by the General Committee.

Dr. VERCO, in opening the proceedings, said—In order that we may know what has already been done in reference to the Intercolonial Medical Congress, as Chairman of the Executive Committee I will call upon Dr. Poulton, the Honorary Secretary to read the report from the committee.

SECRETARY'S REPORT.

Dr. Poulton then read the report as follows:—"May it please your Excellency, Mr. President, and Gentlemen—This Intercolonial Medical Congress of Australasia is the outcome of a suggestion made by the Council of the South Australian Branch of the British Medical Association at the annual meeting held in June, 1886. The Council suggested that a Medical Congress might well take place during the Jubilee of Her Majesty's reign, at a time when the colony of South Australia would be celebrating the completion of the first fifty years of its history, and during the term of the International Exhibition in Adelaide. The members of the branch heartily concurred in the suggestion, and being the only organised Medical Society in South Australia, forthwith appointed a committee to co-operate with the Council in formulating the scheme of such a Congress, and in inviting the co-operation of the profession throughout the Australasian Colonies. Funds were placed at the disposal of the Joint Committee to defray preliminary expenses. The Joint Provisional Committee consisted of Messrs. Cleland, Clindening, Corbin, Hayward, and Drs. Gardner, Poulton, Stirling, Davies Thomas, Verco, and Watson. Early in September a preliminary announcement was posted to all accredited members of the profession throughout the colonies whose addresses could be ascertained, inviting their co-operation. A special appeal was made to medical practitioners in South Australia not members of the British Medical Association. Special communications were addressed to the Presidents and Chairmen of the Medical Societies of Australasia. Notice of the proposed Congress was sent to the medical press of Australia and of India, and to the chief organs of the profession in other parts of the world. Through

good offices of the committee of the International Exhibition representations were made to the Agent-General and to Sir Samuel Davenport with a view to obtaining an adequate display of scientific appliances at the Exhibition. Numerous promises of support were received from representative members of the profession in the various colonies, and the Council of the University of Adelaide generously granted the use of their halls. Reporting to the South Australian Branch of the British Medical Association in October, the Joint Committee was instructed to continue its labours and to place the matter fully in the hands of the profession. A circular was accordingly issued in November inviting all legally qualified practitioners to become members of the Congress, and to assist in carrying it to a successful issue. The invitation met with a hearty and general response, and the first meeting of subscribers was held in Adelaide on December 11. It was then determined that the Congress should be held on the lines suggested by the Provisional Committee. Dr. J. C. Verco was elected President, and an Executive Committee was appointed, consisting of twenty members, with power to add to their number. The Governors of all the Australian Colonies and of New Zealand accorded their patronage to the Congress. Sir Anthony Musgrave, G.C.M.G., a former Governor of this province, and now Governor of Queensland, expressed his special gratification in being associated with a movement so well calculated to benefit the profession and the public throughout Australia. Sir Charles Mitchell, of Fiji, has written regretting that the exigencies of the public service would probably prevent the desired attendance of some of his leading medical officers. The Presidents of all the Medical Societies of Australasia have become Vice-Presidents of the Congress. Special delegates are present from the New Zealand Medical Association; from the Universities of Sydney and Melbourne; and from the Medical Societies of Sydney, Melbourne, Brisbane, Ballarat, and Sandhurst. The Executive Committee conducting the business of the Congress reported progress on July 14 to a meeting of the members. A small Business Committee, delegated by the Executive has met frequently since January. A Reception Committee, under the presidency of Dr. Stirling, has been actively engaged in providing for the entertainment of visitors. The number of members on the list to-day is 155, and includes practitioners from New South Wales, Victoria, New Zealand, Queensland, South Australia, the Northern Territory, and Fiji. The work of the Congress will be conducted in the four main sections—medicine, surgery, gynaecology, and State medicine—under the presidency of Dr. Williams, Mr. Fitzgerald, Mr. Foreman, and Dr. Whittell respectively. The Committee, in submitting this report of its work, would express the hope that this Congress may result in such substantial benefit to the profession throughout these colonies as to warrant the convening of a second session at no far distant date."

Dr. DAVIES THOMAS moved, and Dr. JAMIESON (Victoria) seconded, the adoption of the report.

The motion was carried.

Dr. VERCO then asked His Excellency to open the Congress.

THE GOVERNOR'S OPENING SPEECH.

His EXCELLENCY, who was received with cheers, said:—Mr. President and Gentlemen—it is with great pleasure that I once more find myself taking part in a meeting of an intercolonial character, the third or fourth, I think, that may be said to be directly due to the Jubilee celebrations and to that federal spirit, the growth of which we have noticed with so much satis-

faction. First came the opening of the Exhibition, the great event of the year, followed by that quick succession of visitors, which has done so much to draw the colonies together. This was succeeded by the Intercolonial Chess Congress, and the Intercolonial Rifle Matches, both of them events of much interest and importance in their particular ways; and to-day we welcome from the other colonies, and from distant parts of our own, the members of a noble learned profession, whose conference in the fair City of Adelaide will mark an important step in the development of federal unity, and should prove of far-reaching benefit to the public. Medical conferences have been held before now in older parts of the world, as witness the meetings of the International Medical Congress, of which I understand seven or eight have been held in London and on the Continent of Europe. But this, I believe, is the first held in Australia of an intercolonial character, and I am sure I echo the sentiments of all present when I express the hope that it may be in every sense of the word a success. But a few years ago such a meeting of medical gentlemen engaged in the active business of their profession would have been difficult, if not impossible. To-day it is not only possible but easy, thanks to the rapid improvement that has of late taken place in the means of communication between the colonies, and probably one question to be considered before you separate will be as to the possibility of arranging for similar conferences in the future, thus securing for this Association, now inaugurated, a permanent intercolonial character. The scope and object of this conference will be better explained to you by others, but even to the unprofessional mind it must be clear that great good may be expected from such a meeting as this. Longfellow has said that

Joy, temperance, and repose
Slam the door on the doctor's nose.

Temperance—in other words, moderation, that golden rule of life—it is open to all of us to practise. Joy and repose are not so easily commanded, especially by those who are engaged in the battle of public life; and the hurry and toil of existence will tell on us here in time as they have told for generations on older and more densely peopled communities. We know that even in the delightful and health-giving climate of Australia we cannot escape those ailments to which the flesh is heir, and when the leading medical men from the various colonies meet and, as I assume, they will confer together upon such questions as the sanitary condition of our cities, the prevention as well as the cure of disease, the influence of our climate for good or evil on complaints which are formidable elsewhere, and other kindred questions, it is clear that valuable results may be anticipated and not at all surprising that the public should feel much interest in the conference. I understand that we are indebted for the inauguration of this movement to the South Australian Branch of the British Medical Association, which, acting on a suggestion from Dr. Poulton, took steps for carrying this project into effect. That the exertions of the promoters of the Conference have been so far successful is shown by the pleasing circumstance that we welcome to-day some forty or fifty gentlemen from the neighbouring colonies, together with some 100 from South Australia, all of whom have done us the honour of cordially responding to the invitations which have been addressed to them to be present. On behalf of the people of South Australia I beg to extend to our visitors a cordial welcome. That we are all glad to see them is evident from the printed programme of proceedings, recording as it does the desire of our leading colonists to do them honour. The only fear, indeed, is that in congratulating themselves, as they will undoubtedly be able to

do, on the accomplishment of much valuable work, they may also have to say with the Archbishop of York in Henry IV.—“We are all diseased, and with our surfeiting and wanton hours have brought ourselves into a burning fever.” Mr. President and Gentlemen, I will now no longer detain you. I will only say in conclusion that I feel it an honour to be connected with this Conference as one of its patrons, and hope that the members, one and all, may carry away agreeable recollections of their visit to South Australia. (Applause.)

INAUGURAL ADDRESS.

The PRESIDENT (Dr. Verco) said—Your Excellency, your Honor, Mr. Chancellor, medical gentlemen, and ladies and gentlemen: My first pleasure to-day is to thank the Intercolonial Medical Congress for the honour of my election as President. The history of our meeting has been told by our General Secretary (Dr. Poulton), so that no words of mine are needed to lay this matter before you. It may be easily believed that when this Congress—the first of its kind in the Australian Colonies—was proposed, some misgivings were entertained as to its success; but the distinguished patronage of his Excellency, so readily granted, the patronage of all the Governors of the Australian Colonies, secured by his aid, banished all fear of failure. And when the various Medical Societies and the leading professional men in the sister colonies gave early and hearty support to the movement, we had but to proceed with such arrangement of details that the greatest good to the greatest number might accrue. Such a large gathering as this of busy men—some from great distances—testifies that our Congress is neither premature in time, puerile in its intentions, nor petty in its anticipated results; and we do not feel the slightest diffidence in assuming at this early period the mantle of the prophet, and predicting to those anticipations a large measure of fulfilment. As my audience to-day consists largely of the Congress itself, it can scarcely be necessary for me to justify its existence, or show its advantages. Our roll of members, to the number of 155, is in itself a sufficient vindication, and furnishes witnesses in evidence of its presumed advantages. We need only direct our eyes to the old world, where similar gatherings have become a recognised institution, and see what vast proportions they have already assumed, to form some estimate of their real or supposed value. The seventh session of the International Medical Congress, held in London in 1881, had a register of nearly 3200 members, congregated from every country in the Continent of Europe, from North and South America, from the Cape of Good Hope, from the eastern coast of Asia, and to the number of a score from Australia and Tasmania. The distance travelled by those Australians and Tasmanians might be used as a strong argument in favour of the International Congress, but is doubly strong on the side of an Intercolonial meeting. The long voyage to Europe, even though now contracted within the space of a month, is an absolute barrier to any but the most limited participation by us in an International Congress, for how few, even for such a pleasure, could arrange a three months' absence from duty. But the thousands of miles which separate us from the old world, and preclude a personal intercourse with our medical brethren in the International Congress, create a distinct need for general meetings amongst ourselves. Our continent is not only the antipodes of Europe, but to some extent its antithesis; it is not only isolated, as much almost as distance can isolate, but it is in many of its essential features a different sort of world. We live, we study, we practise amid circumstances very unlike those of Europe, and special to ourselves, and which therefore demand a special adaptation on our part. And

while we could never afford to dispense with the vast stores of medical knowledge which come to us across the seas, or disregard the latest results of that delicate and elaborate research which the very nature of things has hitherto prohibited among ourselves, we can as ill afford to neglect the special recognition of our own surroundings, or the application of that borrowed knowledge, whether extensive or intensive, to our peculiar colonial conditions. And that this special recognition may be full, this adaptation perfect, we need conference. Without doubt many problems can be and must be solved far more satisfactorily in Europe than here. To enter into competition is to court defeat, for neither the wealth of material, the special apparatus, nor the otherwise disengaged labour are to be found among us. But, on the other hand, it is beyond question that much ought not and cannot be done for us; we have a special field for interesting research, special experiences to embrace, special difficulties to overcome—and to help and fit one another in this work we need conference. Let me briefly point out some of these circumstances, which are worthy of our notice, and which demand our mutual attention. (1.) Coming as our enterprising forefathers did a three or four months' voyage over a disinfecting sea, they left many of the terrible scourges of humanity behind. The plagues of the olden time, and of the new, are largely only names and phantoms among us. Hydrophobia, the sweating sickness, relapsing fever, typhus, the cholera, have never from their shrivelled lips breathed pestilence and death over our fair land. Now and again a foul form is seen prowling at our doors; the people are anxiously uneasy at the threatening danger. But hitherto the monster has been strangled upon the threshold. I ask, is not the heritage we enjoy in our freedom from these plagues a special boon? Does it not involve, in common prudence, a special duty, a special vigilance? And since our communication with the old world has become more rapid—and hence the liability to the importation of infection increased—and our intercommunication is more extensive and more speedy, and hence the distribution of infection greatly facilitated, is there not special need for concerted intercolonial action, for discussion amongst ourselves of such subjects as federal quarantine? And how is this emphasized by the virulence and wildfire spread which characterises infectious diseases in tropical and subtropical regions, and still more by the fact that it is in the domain of preventive medicine that the grandest victories of late years have been gained; and, if I can read the times aright, it is in the department of preventive State medicine that the largest, if not the most brilliant triumphs, will yet be won. Then, again, is it not generally recognised that we have diseases in our land—some unfortunately too common—which in Europe are comparative rarities? It is scarcely necessary to mention them in this company. Here is hydatid disease. Do we not meet with it at every turn? Have we not to keep it in mind in our diagnosis of every tumour, external or internal; every collection of fluid, every central nervous derangement, every obstinate cough, every haemoptysis, however trivial? Who has not been surprised by the unexpected apparition of these parasites? Our experience of this disease is probably a hundred times more extensive than that of our European brethren. Here then, is a special subject. To be honest with our patient we must study it thoroughly. To the truth-seeker, here is ample opportunity. We should be teachers to the antipodes in this department rather than learners, and we are proud that there are some among us who are attaining this position. Whence comes pterygium? In England it is a visitor from the tropics. In Australia it has its home. Here it is born and grows to grand proportions. What are

its antecedents? How is it begotten? What is its mode of life? Thousands of instances are to hand. Watch them. Learn and teach the truth. Go up north, into certain districts, at particular seasons, and you will find a complaint called "Barcoo." What is it? A British physician never saw a case. Many a one has never even heard of or read the name. Most know nothing about it. Why? Because we have not yet taken advantage of our opportunities to properly investigate and describe. Here is a complaint whose natural history is unknown, or, at least, unpublished. What an interesting field of observation has been opened up in connection with filaria disease. The story of its elucidation, with which the names of Bancroft, of Brisbane, and Manson, of Amoy, are inseparably associated, reads more like fiction than fact, tracing to the insignificant mosquito a number of serious tropical diseases, and grouping them, despite their diverse forms, into one natural order. Is it credible that the mosquito is the only insect agent in our various obscure complaints, or that the Amoy mosquito is the only offender of its kind? Who will be the Bancroft of other filariae, the Manson of the next mosquito malady? But, again, what an area for survey is opened up in the modification of diseases which are common to the old world and the new. That the types are altered who will deny? That with an identity of disease there should not of necessity be wide variations, who can imagine? Consider the difference between the climate of England and that of any of our Australian colonies, from Queensland in the tropics of the north to Victoria in the south—the humidity of Britain and the aridity of Central Australia. Contrast the millions of population there, crowded within a few thousand square miles, with our three millions of people scattered over as many millions of miles. Compare the social state, with its destitution there, where poverty means disease and death, with the comparative plenty here, where poverty, even when present, means but little more than inconvenience. Does any one ask for evidence that these causes do work? I have measured 300 South Australian immigrants from the old world. They stand 5ft. 7 1/3in., and weigh 146·58. I have contrasted with them 250 South Australians born in this colony. They average 5ft. 8·21in., and weigh 146·42lb. Our native population are therefore exactly an inch taller than their forefathers, and within the fraction of a pound the same weight. What is the significance of these facts? That our southern climate, our social circumstances, our mode of life, are altering the physical constitution of the healthy man, of the growing child, and giving him a taller and more slender form. Whether this be a development or a degeneration I will not say; but it is this—an evidence of the modifying influences which are at work upon our material economy, either for good or for ill. And those same surroundings which, in a single generation, can add one inch to our stature must probably operate in altering the incidence, the prevalence, the manifestation of disease. Our South Australian statistics, for example, covering a period of fourteen years, show that phthisis is less than one-half as common here as in England. Is it exactly similar to that of Great Britain? What is the comparative predisposition of our native population to this complaint? What may we expect in the next generation? What are those influences which are so steadily affecting the extermination of our aboriginal races? Is our rheumatic fever the fac-simile of what we studied in the hospitals of London, Edinburgh, and Dublin? Do we get the pericardial friction rubs with the same frequency or the same intensity; and, if not, why not? Again, we live in a new country. In the old there is scarcely a locality, high or low, whose meteorology has not been

thoroughly worked up and criticised in reference to its suitability for a health resort ; scarcely a spring the chemical composition of which has not been examined with a view to its use as a mineral water ; scarcely a plant of any note whose physiological properties have not been investigated and its medicinal virtues tested, not merely by the wise women of the villages, but by expert pharmacologists of the schools. Here there is a bewildering profusion of novelty and diversity courting our curiosity and inviting our labour. We cannot send our invalids to Madeira or the South of France or Davos Plats. But have we not between the snow-clad mountains of New Zealand or New South Wales and the scorching tablelands of the interior, variety enough to meet all our requirements, were we possessed of information sufficiently definite to warrant advice and action ? We cannot utilize the thermal springs of the Continent of Europe for hydrotherapeutic purposes. We can scarcely afford for our patients the natural mineral waters that have to be bottled 10,000 miles away for any but temporary use. But have we no thermal springs, no mineral waters of our own ? This is the very complaint from which our country suffers. The streams which gush from our artesian bores, are they not thermal enough ? The springs which rise spontaneously in the North, are they not mineral enough ? They are so impregnated with saline ingredients, so brackish that they destroy rather than nourish vegetation, the very cattle cannot drink them ; but yet our technical knowledge of these springs is so meagre, more especially of those most accessible, that we are unable to employ them, and humanity lives in misery or dies prematurely, whilst relief and life are wasting in the sands. We read accounts, we hear the experience, half amusing and half pitiful, of the physical troubles endured by men who are compelled to drink these nauseous waters, how they are worked by them *ad deliquium*, how they break out in boils and blisters, how they swell until they can barely crawl into hospital. It requires but little reflection to perceive in these very troubles the curative treatment for various forms of disease. Could we send our sufferers into those regions and induce these consequences in a measured form we should have a means of relief. But we must know more that is definite and decided before we can act with assurance, and therefore act at all. We have an indigenous flora, largely peculiar to Australia. What use has been made of it medicinally ? Some, but not enough. The derivatives of the eucalyptus, the red gum, and a few others. Here and there a worker records some experiments or some experiences. But whole forests are yet unexplored ready to yield us, shall we prophesy, better antiperiodics than quinine, better anaesthetics than cocaine, better stimulants for heart and cord than digitalis or strychnine. These poisonous herbs of which we read now and again as having proved so deleterious to stock, do not their baneful properties evidence a physiological action upon the animal economy which we only require to understand and to control by fixed principles and regulated doses so as to transform the curse of the cattle into a blessing to mankind ? From these noxious plants we may derive our substitutes or antidotes for belladonna, convallaria, or opium, &c. Let us believe these worthless weeds were given to amplify our *materia medica*. Look, again, at the different conditions under which our work is performed. First, in the city. Here we have no special class of pure consultants such as are found in London, but every man is more or less a general practitioner, and, on the other hand, each one is in turn called in to consult, and that in all departments of medicine, surgery, &c. Further, even our largest cities are not so large but every man's practice overlaps every

other man's, and all come into a kind of competition. Moreover, there is a freedom of intercourse, a circulation of news, a canvass and criticism of medical work and professional men such as is an impossibility in the larger and less democratic cities of Great Britain. Do not these special circumstances entail special responsibilities in relation to our patients, to each other, and to all codes of medical ethics ? It becomes quite a question whether it is wise or right to bind ourselves absolutely by those regulations which may be needful and best in a country where the surroundings are different, and whether on some points we should not be even more stringent. Notice, too, our peculiar position as regards a legal standing. In some of the colonies there is practically no Medical Act. This of necessity gives us a relation to the State and to unqualified practice very dissimilar to that in which a practitioner in Great Britain stands, and this altered relation must free us from some of the conventional usages of medical society, and at the same time imposes on us extra obligations and places us in positions of peculiar difficulty. In discussing also legal recognition by our respective Legislatures we should regard the special characters of our colonial Governments, and still more the special exigencies of colonial life—not only in the large centres, but in distant parts as well—that we may neither hamper a free profession nor a free people by a rigid and unsuitable law, nor tantalise a learned and certificated profession, and blind a public which has often but little will and less material for discrimination by an act which is practically lawless. Look again at the isolated country practitioner, hundreds of miles from the capital, in his thinly populated district. For months together he is entirely cut off from the society of his professional brethren, without a chance of interchange of ideas or the stimulus even of competition. Skilled assistance is obtainable. He must do with his own unaided hand what is resolved by his own unsupported judgment. Such a state of things is almost unknown in the old country. The remedies and the appliances, too, at his command are often of the simplest nature and most limited supply, and with these he must do his best and improvise according to his need. Picture a medical man, on a newly-discovered gold-field, whither there have rushed within the course of two or three weeks thousands of men, living as they have never lived before, in flimsy calico tents; their work unusual, laborious, and exposed ; their diet often insufficient, inferior, unvaried, and badly prepared ; their drinking water brackish and contaminated with decomposing organic matter ; the very air polluted by unsavoury and insanitary surroundings. Picture the practitioner working according to the methods of a London Hospital. No, he must grasp the situation and adapt himself to it ; do what can be done with the means at his disposal, meagre though they be ; and accommodate his treatment to the circumstances, however unfavourable and unusual. In greater or less degree the same applies to us all, for the excessive heat of our summer, continued for many days together, not only relaxes the fibre of the healthy, but often kills outright the very young, the old, and the feeble. Have we not to tax our ingenuity and our resources to the utmost to obviate its fatal tendencies in the case of delicate infants and of those suffering from pyrexia, whose probabilities of life are reduced by the serious heat of the houses and the air ? And so in many other particulars our surroundings are unlike those of medical men in England, and if we are wise our manner and our methods will vary in an equal ratio, just as the special characters of our colonial land business brought as a wise and natural consequence the Real Property Act, in place of the cumbrous methods of land transfer still in

force in England. So should the exigencies of colonial life result in wise and simple adaptations in the domain of medicine; and whether it be the disposal of our sewage or the disposal of our dead—not to follow blindly the sentiments of society or the example of others, but learn what had best be done by us, and do it—taking all the experience of others, but not failing to combine it with our own. To resume, then. There is reason why Australian professional men should meet in congress—that they may make common property what facts peculiar to Australia have been observed in disease, what methods employed have proved most appropriate in their hands, what new remedies Nature has provided at our doors, what suggestions relating to medical ethics or legal status arise out of our colonial life, and that an opportunity may be afforded those far away to contribute their unique or exceptional experiences for the general interest, and to reap the pleasure and profit of that social and professional intercourse which is so rarely theirs. Now, I do not imagine that our Congress will accomplish during this week all I have indicated as lying within our province. Even the best of us required to be educated up to the possibilities, the best methods, of such gatherings. To know we have fairly and unitedly begun will be a satisfaction. Especially will this be the case if, as I hope, it shall be decided before we conclude our business to call the Congress together again, and to regard this gathering in Adelaide as its first session only. This will be for you to determine. One suggestion only I will make if the decision be favourable. Let the sessions be neither so frequent as to make them impracticable, nor so seldom as to lose their interest. Nor do I presume our arrangements will be found perfection. The committee has laboured under the disadvantage of having to inaugurate, and has therefore been compelled to take to itself certain powers, because they could not be conferred. It has had to draw up a tentative programme for the simple reason that it had no previous experience as a guide. This disadvantage will not be the lot of future executives, and must be our apology for any dislocation of appointments which may occur. His Excellency has done us the honour to open our Congress, for which our heartiest thanks are justly due. We shall find abundant opportunity for honest work in the four sections which have been arranged. Let each one be devoted to it with a threefold motive—the improvement of ourselves, the benefit of our fellows, and the advance of truth. (Loud cheers.)

Dr. STIRLING said he was only fulfilling the wish of every one present in expressing to his Excellency their deep sense of gratification at his presence there, both in the capacity of Her Majesty's representative and as patron of the Congress. He was sure, if the Congress was to achieve success—as there was every prospect it would—that success would be largely due to the assistance received from those outside the profession. (Hear, hear.) He moved a vote of thanks to his Excellency.

Dr. W. C. WILKINSON, of Sydney, seconded the motion, which was carried by acclamation.

Dr. J. O. CLOSS (Invercargill) moved, "That a special meeting of this Congress be held on Thursday, at 2 p.m., in the library of the University, to consider the advisability of holding another Medical Congress at some future date in one of the Australian colonies, and other matters of interest to the medical profession."

The Hon. J. M. CREED, M.L.C., M.R.C.S., seconded. This Congress could not but be of immense benefit to the profession through the interchange of ideas. The President, in his eloquent and learned address, had spoken of the difficulties practitioners had to encounter in the bush. He knew of this from experience, for he had been a surgeon on the exploring expedition in

North Australia in 1867, and had practised in the country districts of New South Wales, when residing one hundred miles from any other practitioner.

The motion was carried.

Archdeacon FARRE moved a vote of thanks to the President for his able address, to which both the members of the Congress and the visitors had listened with such great interest. (Hear, hear.)

The CHIEF JUSTICE seconded. He felt it was a source of great satisfaction to South Australians to know that they were so well and ably represented on this occasion.

The vote was carried with loud applause.

Dr. VEROO thanked the audience, and adjourned the sittings of the Congress until Wednesday afternoon, August 31.

CONVERSAZIONE AT THE UNIVERSITY.

On Tuesday evening the members of the Congress and their friends, to the number of about 800, were entertained by Chief Justice Way, in his capacity as Chancellor of the University, at a brilliant conversazione, held in that building in honour of the visitors, for which a most attractive programme had been prepared. In the Chemical Lecture-room Professor Rennie gave a demonstration of spectrum analysis, illustrated by the electric lamp; and in the Physical Lecture-room Professor Bragg illustrated the influence of sounds and jets. There were also miscellaneous experiments in the Chemical Laboratory, and demonstrations on the eye with the ophthalmoscope, while the Physiological Laboratory, with Dr. Stirling and his pupils at work, was open for inspection. Refreshments were provided in the rooms adjoining the Library, as well as in the Museum and Physical Laboratory. One of the special attractions of the evening was a concert given in the Library, admirably arranged by Professor Ives. In accordance with the Professor's custom, special prominence was given to local talent, the greater portion of the programme being selected from the works of University students.

SECOND DAY.

Wednesday, August 31.

The Congress met at the University on Wednesday afternoon at 3 o'clock.

The PRESIDENT (Dr. Verco) mentioned with regret that Dr. Williams (of Melbourne), Chairman of the medical section, was through ill-health unable to attend the Congress and deliver the address on "Medicine." Professor Allen had undertaken to read the paper. The Congress elected Dr. Thos. Dixson, Lecturer in Materia Medica at the University of Sydney, as Chairman of the section of medicine.

ADDRESS ON MEDICINE.

Professor ALLEN then read the paper written by Dr. J. Williams on "Advances of Modern Medicine," from which we extract the following:—"If we ask, what is the chief feature of modern medical work? I think the answer may well be—the attempt to grasp the natural history of disease. By this I mean, not merely the establishment of the connection between certain clinical signs and symptoms noticed during life and certain morbid conditions found after death, but the endeavour to trace the whole history of disease in the living body; to learn its origin and its course; to know the laws which govern its progress; to distinguish processes which are compensatory and conservative from those which are harmful and destructive; to recognise the inter-dependence of the several organs in disease; to appreciate the value of the element of time in the development of morbid conditions, and in the determination of the symptoms which arise from them;

rightly estimate our power to arrest or mitigate or guide the progress of disease. Step by step knowledge has been obtained of the history of disease in the living body, of its origin and course, and the laws which govern its progress. The gradual character of the advance is strikingly illustrated in the case of enteric fever. To rightly estimate our power to arrest or mitigate or guide the progress of disease is the consummate flower of medical science. Exact diagnosis and prognosis have their own especial values, even apart from all question of treatment; but it is by the power to arrest disease, to prolong life, to relieve suffering, that the medical profession must justify its existence. Various are the agents which we must employ for these ends, various our real knowledge of the agents which we use. No small part of our treatment is still empiric, based only on experience of results; yet year by year the science of rational therapeutics is growing wider and more precise; the chemist, the physiologist, the pathologist, and the physician now join hand in hand; and, far off, we look forward to the time when the mass of undigested facts and details which now embarrass us shall have passed through the crucible of the minds of other generations, and shall be cast in perfect mould, embodying in the just proportion of its different parts that natural history of disease of which I have feebly tried to speak. Briefly, then, let me, before ending my remarks, indicate some of the means whereby we may favour the progress of medical science and of the healing art. In the first place, it is absolutely necessary that the physician and the pathologist should work together, otherwise the observations of both are imperfect and of comparatively little value. Now and then a man like Bright, abounding in energy, becomes eminent in both these spheres, and leaves an imperishable name for his services to medicine. But, as a rule, the tendance of the living and the examination of the dead must be entrusted to different officers. Collation of their respective records is good, but it is not the best. There is needed a thorough sympathy, an active co-operation in enquiry between physician and pathologist, which shall lead each to assist, to verify, to correct the work of the other. I fear that such union is far from common, and I therefore urge this consideration upon the notice of the officers of our metropolitan hospitals and the teachers of our medical schools, who almost alone have the opportunity to co-operate in such manner. But though the large hospital is the natural home of medical enquiry, it has its own inherent defects, in that hospital practice deals with a patient only during some very limited portion of his career. The causes of disease, the influence of family tendency and of personal surroundings, the connected history of patients from birth to death, the questions of idiosyncrasy in treatment, all these form the domain of enquiry for the private practitioner. In these matters, too, the country physician has many advantages over his *confrères* in the larger cities and towns; he has more accurate and continuous knowledge of his patients, he deals with questions in simpler form, and hence his observations should be most valuable. Without doubt the present isolated professional life of the bulk of country practitioners involves a grievious waste of useful knowledge which should be conserved for the general good. The remedy would seem to be the adoption of the system of collective investigation. At the Copenhagen Congress, in 1884, Sir William Gull explained the work which was being done by the Collective Investigation Committee of the British Medical Association. Fifty sub-committees had already been formed in the United Kingdom, including 1,000 members. At the close of his eloquent address it was resolved to form an International Committee for the

Collective Investigation of disease. The various countries of Europe, with North and South America, are represented on that committee. Might not one result of this Congress well be the formation of an Australasian branch of that committee, so as to give purpose and method to the observations of the general body of our practitioners? Lastly, in addition to co-operation between the workers in the vast fields of research afforded by our hospitals, and to some method of collating the experience of physicians in all parts of the colonies, I would in a few words refer to the necessity for special enquirers. The life of Duchenne aptly illustrates my meaning. Early acquiring a taste for electro-therapeutics, and finding no scope for his enquiries at Boulogne, he proceeded to Paris in 1842, and there set himself to the study of the nervous and muscular mechanism in health and disease. He accepted no official appointment, but wandered through the various hospitals, eagerly investigating all cases that bore upon his studies, following them up from hospital to hospital and to their private retreats, and thus at last left behind him that series of discoveries which is treasured heirloom to succeeding generations. Is not the time coming in the history of these colonies when special research shall be, not the characteristic of a few workers widely scattered from one another, but a spirit moving everywhere, impelling the best minds to bend themselves with all their energies to add something tried and sure to the sum of human knowledge? Thus may we aid in realizing the words of Graves, true to some extent even in his day, more true now, but pregnant with hopeful prophecy for the future:—"The reason of man is now more fully employed than at any former period; a vast store of mental power, a vast mass of mind is everywhere at work; what formerly was vainly attempted by the labours of a few is now easily accomplished by the exertions of the many. The empire of reason, extending from the old to the new world, from Europe to our antipodes, has encircled the earth; the sun never sets upon her dominions, individuals must rest, but the collective intelligence of the species never rests; at the moment one nation, wearied by the toils of day, welcomes the shades of night, and lies down to seek repose, another arises to hail the light of morning, and refreshed speeds the noble work of science."

Afterwards the Congress held sectional meetings in different rooms, when the following papers bearing on medicine, surgery, State medicine, and gynaecology were read, and in some cases discussed. Medicine: "Fear as a factor in producing many of the alarming symptoms following the bite of Australian snakes," by the Hon. J. M. Creed, M.L.C. (Sydney); "Some remarks upon the South Australian climate and their influence on phthisis," by Dr. Astles, M.D. (Adelaide); on "Grindelia Robusta," by Dr. Thomas Dixson, M.D., Lecturer on Materia Medica at the Sydney University. Surgery: "Case of scrofulous pyelonephritis, removal of kidney by Langenbeck's incision, recovery," by Dr. H. W. Maunsell, M.D., T.C.D., Honorary Surgeon of the Dunedin Hospital; "Hydronephrosis, removal of kidney, recovery," by Dr. Fell, Wellington, New Zealand (read by Dr. Closs). Demonstration and illustration, by Dr. Maunsell, (a) on the use of carver's tools in hard cleft palate; (b) extroversion of bladder; (c) removal of foreign body from bladder by suprapubic operation; (d) a method of radical cure of femoral hernia. Gynaecology: "History and progress of ovariotomy in the Australian colonies," by Dr. Pincock, M.B., &c. (Ballarat). State Medicine: "The Medical Profession in relation to the State," by Dr. Neild; "The State, the Practitioner, and the Public," by Dr. E. C. Stirling.

THIRD DAY.

Thursday, September 1.

VISIT TO THE SEWAGE FARM.

In the morning about fifty members of the Inter-colonial Medical Congress, the larger proportion of whom were members of the profession from the other colonies, paid a visit to the Sewage Farm. Owing to the wet weather things were seen at their worst, but all expressed themselves as highly pleased with what they saw. After inspecting the place where the whole of the sewage matter from the city and those parts of the suburbs which are connected with the system is received and distributed over the land, and the whole system had been fully explained, the party visited the buildings in which the cattle are kept, the piggeries, and other buildings. The cattle were not in a very clean state, but otherwise the visitors were loud in their praises of the management of the Farm, and expressed their approval of the system.

THE NEXT CONGRESS.

At 2 o'clock a special meeting was held to decide when the next meeting of the Congress should take place. Professor ALLEN moved, and Dr. CLOSS seconded, "That the next Congress be held in Melbourne." This was carried, and he then moved, "That the next Congress be held in Melbourne in 1890, or at such time as the Medical Societies of Victoria shall determine." The motion was carried unanimously. The meeting decided that another special meeting be held on Friday, after the paper on "State Medicine" was read, to elect the President of the next session of the Congress.

SURGERY.

At the general meeting of the Congress Mr. T. N. FITZGERALD, F.R.C.S.I. (Melbourne), delivered an address on "Surgery," in which he said : "If we consider what have been the most important events which have marked the progress of surgery, the first will be found in the discovery long ago, by Ambrose Paré, of the use of the ligature, without which even the coarsest operations were impossible. This discovery led up in more recent days to the practice of torsion, and to the employment of catgut and tendon ligatures, which have rightly, to a very large extent, replaced the hempen thread. The next discovery of prime importance belongs to our own era, and was given to the world by members of the English-speaking race. Need I say that I allude to the invention of anaesthesia by nitrous oxide, ether, and chloroform, through which Horace Wells, Morton, and James Simpson made practicable a host of operations which formerly could not be attempted ! This discovery, coupled with other advances, has completely revolutionized the entire *pratique* of surgery. Some of us can well remember the operating theatre of old, ensanguined like a slaughter-yard, the air rent with the shrieks of the unhappy victims quivering under the knife of the operator, whose one object was of necessity to hurry over his work, too often sacrificing safety to celerity. Prior to the days of anaesthesia, the periodical literature of surgery represented energy rather than research. Conservative surgery was not greatly in favour, and brilliancy was the chief object aimed at. The records of hospital practice were rather boastful than instructive. The difficulty of an operation, rather than the benefit to accrue from it, was most in men's minds, and unquestionably, on the score of boldness, there was nothing lacking. The story of anaesthesia is extant, and is written in all languages. So, too, is the story of the sudden development of operative surgery, which followed immediately. Both operations and operators multiplied with marvellous rapidity. To pass to one

other advance, allusion to which after the mention of chloroform will not be an anti-climax. I refer to the sudden improvement which took place in what may be designated 'the hygiene of surgery.' Extraordinary as it may seem, it is, nevertheless, a fact that until the conclusion of the Crimean War no attention seems ever to have been paid to the lodgment of the sick or to the construction of hospitals. Disastrous as it was in many respects, the Crimean campaign taught the lesson that surgical fevers were more fatal than typhus, and quite as infectious. And coming more to modern surgery, and especially that part of it which appertains to our own land, we find that Australian surgery possesses two peculiar features—firstly, the prevalence of hydatid disease ; and, secondly, the absence of rachitis. Another feature which strikes a surgeon in Australia is the almost total absence of deformities due to inheritance or vicious osseous nutrition. A student may go through the whole of his curriculum without witnessing a genuine case of rickets, the beaded ribs and bowed legs being almost unknown in our wards. MacEwen, in Glasgow, a town whose population is not greater than that of Victoria, records his thousandth operation for genu valgum. I venture to say that if the whole of our colony was searched, not five cases suitable for operation would be found. Any observant person walking down one of our side streets, and subsequently through a by-lane in a European city, will at once notice the difference. In the latter he will encounter misshapen, distorted little wretches, with enlarged heads, depressed noses, and curved backs, with bent limbs and legs, all over the place. On the other hand, look at the Australian child, even emerging from the lowest den—he is straight-limbed and level-featured ; a neglected club foot may possibly be met with, and occasionally one runs against a 'Bolteux' from chronic hip disease, but rachitis and bone distortions arising from other causes than fracture are almost unknown. With reference to Continental surgery generally, I deliberately formed the proud conviction that the surgeons of the old country still decidedly hold their own. I had the pleasure of seeing Mr. Christopher Heath operate on a case of disease of the jaw, and was delighted with the brilliancy and precision of his work. Sir Henry Thompson's lithotripsy cases, of which I witnessed a good many, interested me strongly. Nor shall I soon forget the excellent surgery exhibited by that distinguished veteran, Mr. Savory, who showed me many patients treated without the cumbersome precautions of Listerian asepticism, but with that perfection of cleanly surgery of which Mr. Savory is so able an exponent. I would be the last to deny to Professor Lister any of the credit so fully due to him for his admirable investigations, and for the impetus which he has given to the observance of scientific cleanliness in surgical practice. But I hold, with many others, that the secrets of antiseptic surgery have yet to be revealed, and that in the meantime too much is made of processes which are unnecessarily cumbrous. I am pleased to believe that here in Australasia we are not wanting in the pursuit of science. We have careful enquirers and bold and skilful operators. It would be invidious for me to single out any names for special mention, but I must take this opportunity of congratulating my *confrères* of Adelaide on the scientific spirit which animates them, on the value of their published researches, and on the brilliancy of their practical surgery."

After Mr. Fitzgerald had read his lengthy and interesting paper on "Surgery," the Sectional Meetings were held. The following is a list of the papers which were read :—"Hydatid Disease of Brain," J. Davies Thomas, M.D. ; "Tuberculosis," F. W. Eisner,

F.R.C.S.I.; "Hydatid Disease" (a case), J. W. Springthorpe, M.D.; "Anæmia," J. Reid, M.D.; "Epilepsy" (cases), J. W. Springthorpe, M.D.; "Dilatation of Stomach," F. W. Elsner, F.R.C.S.I.; "Extirpation of Larynx," W. Gardner, M.D.; "A New Method of Drainage after Abdominal Incision," Mr. O'Hara; "Ophthalmic" Papers (two), Dr. Symons; "On Operation in Compound Depressed Fracture of the Skull," Mr. Musket; "Oöphoritis and its Relation to Oöphorectomy," Dr. J. O. Closs; "On Shortening the Round Ligaments," J. Foreman, M.R.C.S.; "The Alexander-Adams Operation," W. Gardner, M.D.; "The Relation of the State to the Profession and to the Public," W. L. Bickle, M.R.C.S.

The last paper evoked an interesting discussion, in which the Honorable J. M. Creed, M.L.C., Drs. Whittell, Abramowski, and Stirling took part.

In the evening the members were entertained at an "At Home" at Government House.

FOURTH (LAST) DAY.

Friday, September 2.

The final meetings of the members of the Congress were held on Friday afternoon. After an exhaustive and interesting paper on "Gynaecology" by Dr. Foreman, of New South Wales, Dr. Whittell (President of the Central Board of Health) read a paper on

STATE MEDICINE.

Dr. WHITTELL dealt first with the action of the State in relation to existing disease. He had been reading the voluminous evidence taken by the Commission appointed by the New South Wales Government to enquire into the law respecting the practice of medicine and surgery in that colony, and the revelations and confessions were astounding. Those who had the best means of knowing had assured him that evils of the same character as those brought out in the Sydney report were rampant in South Australia. He looked upon it as a scandal in any community that a man should be permitted to undertake duties that involved human lives without giving some evidence of his qualifications. This concerned the State rather than the profession. The business of the State was to know that a man had the knowledge. To ascertain that, he inclined to the German method of State examination by independent examiners appointed by the Government, who should require from every candidate proof of a sufficient knowledge of the anatomy of the human body, of its functions, and of its diseases to qualify him to undertake the responsible duties of a medical practitioner. Passing on to consider the action of the State in the prevention of disease, he dealt specially with the specific febrile group. Small-pox, perhaps the most contagious disease that was known, had never gained a permanent footing in Australia, and against that and Asiatic cholera, quarantine presented itself as the most promising means of defence. In these days of rapid communication and the facilities for travel from one colony to another by land were so great, a necessity had arisen for some combined action for federal quarantine, which should enable us to meet the danger at the earliest opportunity when infected ships were approaching Australian coasts. The point from which we had most to fear was in the direction of the northern and north-eastern ports. Our Northern Territory and Queensland lay dangerously near to thickly populated countries which were seldom or never free from small-pox. The Chinese from those countries kept up a constant immigration into our northern ports, and it was possible that a patient might become infected with smallpox in Hongkong or Sumatra, might

sail to our Northern Territory, land there, mix with the population, and be lost sight of before the outward signs of the disease became manifest. Two such cases had happened within the last three months. We required a system of federal quarantine, with its station at or in close proximity to Port Darwin, where the strictest inspection should be made, and where no vessel should be allowed to pass on until all risk of its bringing infection should have ceased. He was not without misgivings that in spite of all the barriers we might set up smallpox would sooner or later become endemic in Australia. We should avail ourselves of every defence which gave promise of increased protection. Within the last few years bacteriologists had hit upon the probable scientific basis of the discovery which led to vaccination. It was known that the germs of some diseases could be modified in their degree of activity by a change of the conditions under which they grew. It was probable that vaccine in the cow was a modification of the smallpox virus as we found it in man. Overwhelming evidence had been gathered in all countries that wherever the practice of vaccination had been extended the ravages of smallpox had diminished, and there was reason to believe that vaccination placed in our hands a means of prevention which, if properly availed of, would afford our population the fullest security against attack, even though our quarantine arrangements might be found ineffectual. In 1881 the English census was taken, and it was found that of 55,000 unvaccinated children 782, or 1 in 70, died through this disease. Of the 916,784 vaccinated children only 126, or 1 in 7,300, died from the same cause. If vaccination was to be compulsory, parents had a right to expect that the lymph should be carefully selected. In South Australia no lymph was sent out which was not vouched for by a medical practitioner or examined at the central office. Typhoid fever already existed in our colonies. We must admit to our shame that it had not only taken up a permanent home in our midst, but that it threatened to become even a greater scourge here than it had proved to be in the mother country. It was proved beyond doubt that filth and typhoid were intimately associated. He was not questioning the habits or cleanliness of families in which typhoid might appear. Too often they were the unfortunate sufferers from the negligence of others. The contagion might be carried miles away from the homes of the affected. It might be introduced into our houses from dairies at long distances. It might contaminate our wells or other sources of water supply by percolation from closets or by drainage from the surface. It might lie dormant in the soil for an indeterminate time, or it might poison the air either from leakage of closet-pipes or from cesspools where faecal matter was allowed to accumulate. There was no disease which could be more readily stayed if promptly followed by a strict observance of instructions which Boards of Health were in the habit of issuing in districts where it made its appearance. In the Australian Colonies we had copied the example of the mother country and had entrusted the administration of sanitary laws to Local Boards of Health. In South Australia the Central Board administered the Health Acts in places where no Local Boards had been appointed. The Local Boards had large powers for the removal of nuisances, the cleansing of streets, the scavenging of towns, the making of private roads, the prevention of adulterations of food, the drainage of private houses, and the prevention of overcrowding. The Central Board had further powers to make such regulations as it might deem expedient for removing or preventing the spread of infectious diseases. Questions of quarantine are also referred to it. It had also powers

to set on foot any enquiry it might think fit relating to the public health, and to compel the attendance of witnesses. It might also direct the Local Boards to do anything that might lawfully be done to carry out the provisions of the Health Acts. The administration of the Vaccination Act was also in the hands of the President of the Board. By means of the Local and Central Boards we had undoubtedly made vast strides in the way of sanitary improvements, but when we turned to the returns of mortality from preventable diseases we felt keenly that the work that yet remained to be done was far in excess of anything we have yet accomplished. The question was in what direction shall we look for improvement? it should be opening up a somewhat delicate question when he said that the principle of appointing members of Corporations or of Shire or District Councils to be the Local Boards of Health did not commend itself to his judgment as satisfactory. (Hear, hear.) A Council might be very apt at municipal affairs, but might have neither the will nor the ability to perform efficiently the duties of a Board of Health. If the two qualifications happened to exist in the same Council the combination was an accidental one, and liable to be broken every time there was a new election of members. As a rule the duties were performed in a loose manner, attention to the public health being held by members and officers as subordinate to the other duties of the local Councils. He did not wish them to believe that Local Boards had obstinately refused to discharge their duties when they had been pointed out to them. If we must have Local Boards let us have men selected on account of their knowledge of sanitary laws and who would act independently of local influences. Under any circumstances there must be some central authority armed with the fullest powers to control and direct the local bodies whenever action was desirable. Whether we had a Minister of Health or a Local Government Board as at home, or a Central Board of Health as in Australia, the power should be placed in the hands of men whose knowledge entitled them to speak with authority. Among the new methods of preventing the spread of disease there were two which Australia had not yet adopted, but which were regarded by sanitarians at home as the most important of recent advances. He referred to the registration of infectious diseases, and to the undertaking, under the authority of the State, of original research into the etiology of disease. Registration was dependent on notification. Early information enabled the authorities to take immediate action, to put out the fire as soon as the first glimmer of the conflagration was discovered. It was impossible to overrate the advantage of this timely notice. In the Victorian Health Act the compulsory notification of dangerous infectious diseases had been thrown on the householder, but from some complaints in the last report of the Central Board he suspected there had been some hitch in securing it. In this colony about three years ago the Attorney-General carried a Bill through one branch of the Legislature, which would have secured all that was necessary, but it was so "improved" before it became law that our Central Board was able to insist on the notification of only some three or four diseases which never had been, and he trusted never would be found in our midst. The prosecution of original researches into the etiology of disease had come to be recognised in the old countries as an important duty to be undertaken by central authorities. The work of Koch in the laboratory of the German Board of Health, and his journey to Egypt and thence to India to bring his special mode of investigation to bear on the etiology of cholera, would be fresh in their memory. They would

also have in their minds the work of Klein in the many investigations he had undertaken at the instance of the Chief Medical Officer of the English Local Government Board. This work was not that of the private practitioner, nor in some cases was it desirable that while engaged in it he should undertake practice. The whole nation had an interest in it, and therefore it was the right work for a Government department to undertake. In Australia we have many questions relating to the public health which awaited solution. We spent money lavishly in destroying our rabbits or our sparrows. We protected our crops, our stock, and our grass. Was man of less value than these? Was it too much to ask that some little of the country's expenditure should be given for the protection of human life, or that money be expended in searching out the causes of disease from which every one of us was liable to suffer? (Applause.)

VOTE OF THANKS.

Dr. GARDNER (Adelaide) had great pleasure in moving votes of thanks to those Presidents of sections who, at great difficulty and inconvenience, had prepared the addresses on medicine, surgery, gynaecology, and State medicine, to which all had listened with such pleasure and profit.

The vote was carried.

THE NEXT PRESIDENT.

The Hon. Dr. CREED (Sydney) proposed that Mr. T. N. Fitzgerald, of Melbourne, should be the President-elect of the next Congress, and in doing so he paid a tribute to the value of Mr. Fitzgerald's work.

Dr. GARDNER (Adelaide) in seconding, said he knew of no gentleman who was more fitted to hold the position.

The motion was carried with acclamation.

Mr. T. N. Fitzgerald (the President-elect) briefly thanked the meeting for appointing him to such a responsible position, which he would undertake with great pleasure. He trusted that his *confrères* and friends would assist him in the heavy work which would be necessary. He mentioned that several of the leading members of the profession in London had told him after the Congress of Copenhagen that if they had sufficient notice they might come to an Australian Congress.

PUBLICATION COMMITTEE.

A Publication Committee, consisting of the President, the Hon. Dr. Creed (Sydney), Dr. Jamieson (Melbourne), Professor Watson, Drs. Stirling, Görger, Thomas, and Cleland (Adelaide), was appointed to compile a record of the proceedings of the Congress.

SECTIONAL WORK.

Before the State Medicine Section, the Hon. J. M. Creed, M.L.C., of Sydney, read an exhaustive and interesting paper on "Cremation."

Mr. James Rudall delivered an address on the Government responsibility in regard to sight-testing for land and sea service, and gave as his conclusions that it was the duty of the Government to pass laws which could not be evaded, to ensure the public safety in travelling. No law would be effective which did not provide a definite standard of sight to be maintained for the examinations being made by technically competent persons. The respective Governments should have an office with the necessary staff of medical examiners, where a permanent and accessible record of the sight of every candidate passed should be kept, and a record of the cause of rejection of unsuccessful candidates. The examiners would serve for the examination of the sight of all railway and marine signalmen, locomotive engine-drivers, pilots, soldiers, sailors, and policemen.

Some interesting notes on "Modification of symptoms in Central Australia," was laid before the Con-

gress by Mr. J. P. Baker, F.R.C.S. of Strangways, South Australia.

An elaborate paper on "The Thermal Springs District of New Zealand and the Government Sanatorium at Rotorua" was submitted by Dr. Ginders, of New Zealand. The acid-sulphur baths were generally rich in sulphates—notably, sulphate of alumina—and had a highly stimulant action. The alkaline waters, on the other hand, had a soothing effect on the skin, and were of great value in eczema and other cutaneous ailments. In this alternative stimulant or sedative action on the nervous and vascular apparatus of the skin lay the whole secret of the therapeutic power of thermo-mineral baths. The effect of temperature, however, was important. After dilating on the delightful climate at Rotorua, Dr. Ginders mentioned that the thermal springs district of New Zealand comprised an area close on 100 square miles, and its altitude ranged from 1000 to 2000 feet above sea-level. No spring had obtained a higher reputation than that known as the Priest's Bath. The character of the water was sulphurous, aluminous, and strongly acid, and its temperature varied from 98° to 106°. The ailments in which the springs had proved useful were enumerated at length.

DINNER TO THE VISITORS.

In the evening the President and South Australian members tendered a very successful dinner to the visiting members of the Congress at the Town Hall Exchange-Room. About eighty gentlemen sat down to a well-prepared banquet, amongst the guests being His Excellency the Governor, His Honor the Chief Justice, Sir Thomas Alder, the Rev. W. R. Fletcher (Vice-Chancellor of the University), and Mr. J. H. Symon, Q.C.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH B.M.A.

A GENERAL Meeting of the Branch was held in the Royal Society's Room on Friday, September 2, 1887, at 8.15 p.m. Present: G. T. Hankins, Esq., in the chair, Drs. Clubbe, Worrall, Chisholm, Twynam, Brady, McDonagh, Pockley, Crago, Fiaschi, Thring, Scot-Skirving, O'Neill, Parker, Kendall, and W. A. West.

The minutes of the previous meeting were read and confirmed.

Dr. G. E. TWYNAM read a paper on a case of "Thyroidectomy." The patient was examined by the members.

Dr. BRADY congratulated Dr. Twynam on having followed the recognised plan of operation, namely, of removing only a portion of the gland instead of the whole. He (Dr. Brady) thought Dr. Twynam wrong in stating that Mr. Horsley was the first to mention anything about the question of myxoedema, as the idea was first started by Kocher. It has now been fully demonstrated by experiments upon dogs, that where total excision has been practised, none have survived. One case he (Dr. Brady) intended bringing before the Branch, but the patient was lost sight of, where the removal was accomplished by electrolysis.

Dr. SCOT-SKIRVING asked Dr. Twynam if, in this case, Von Graefe's sign had been looked for—also as to the cardiac condition. He also remarked on the resemblance between exophthalmic goitre, in which disease

you had a certain organ, viz., the thyroid gland, involved, accompanied by certain definite symptoms, implicating several organs, and Addison's disease, which trouble in the suprarenals was accompanied by a striking series of symptoms also causing change, trophic and functional, in tissues and organs widely remote.

Mr. G. T. HANKINS said there were many points of interest surrounding this case. He (Mr. Hankins) was present at the first operation; but by some means missed the major one. One of the minor points brought out by Dr. Twynam, which was well worth noting, was the tapping of a vein on the tumour, to see if the vessels were properly secured. Dr. Brady's remarks as regards the partial removal were very valuable. No doubt the removal of portion of the tumour will be sufficient to relieve the patient in most cases.

Dr. TWYNAM in reply, said, that Dr. Brady had misunderstood what he (Dr. Twynam) had said, as he used the words "worked out by Mr. Horsley" and not that Mr. Horsley had first mentioned the matter. In this particular case he saw nothing else but to operate. The risk in injecting perchloride of iron, &c., was that of coagulation and of the clot being carried to the heart. Some object to operate in cases like this, but the question arises, how long should we continue to paint with iodine, &c.

Dr. BRADY said he would like to add a few words if he were in order. With regard to Dr. Twynam's remark as to how long we should continue the painting. He (Dr. Brady) thought that we should not operate too quickly, if the swelling were merely a disfigurement we should be satisfied to wait until urgent symptoms showed themselves.

Dr. SCOT-SKIRVING read a paper, opening a discussion on "Tracheotomy."

Dr. THRING said he thought that an early operation in a case was sure to have a better chance of recovery than when the patient was allowed to get too bad. With regard to the use of two pairs of dissecting forceps in the operation, he did not quite agree with Dr. Skirving. Then, as to the use of chloroform, it has been stated by Brown-Sequard that after the first incision in the skin in the lower part of the neck, the patient ceases to struggle, if this be the case, why use an anaesthetic.

Dr. POCKLEY said he would like to ask Dr. Skirving how they were to judge as to a high or low operation, for although he (Dr. Pockley) had not done many operations of this kind, he had assisted at a good many, but had never seen the isthmus. As to the kind of incision to be made, he remembered on one occasion to have seen a plunge, as suggested by Dr. Skirving, made, and the knife penetrate the opposite wall of the trachea.

Dr. WORRALL quite agreed with Dr. Pockley's remarks as to the high or low operation, he had never seen the isthmus when operating. In cutting down, he made a practice of catching hold of the knife about a quarter of an inch from the point, thus avoiding any risk of touching the opposite wall. With regard to the use of chloroform, he certainly knew of one case where the child had died from its effects. Dr. Skirving had not mentioned anything about the medical treatment of these cases.

Dr. BRADY said he was quite in accord with Dr. Skirving in nearly all he had said, but did not agree that once membrane got into the larynx, a tracheotomy should always be performed, this, at any rate in the case of adult sufferers.

Dr. McDONAGH also spoke to the question.

Dr. TWYNAM proposed that the discussion on the paper be adjourned until the next meeting—seconded by Dr. KENDALL, and carried.

CROSS V. GOODE.

AT the conclusion of the general monthly meeting of the Medical Section of the Royal Society of New South Wales, held at the Society's rooms in Elizabeth-street, Sydney, on August 19, a meeting of the medical profession was held, Dr. MacLaurin in the chair, to consider what steps should be taken in the case of Cross v. Goode. The chairman said they had been called together for the purpose of expressing their sympathy and condolence with a fellow professional man who had met with a great misfortune in being cast for damages of a very heavy character. They were not there to express any opinion in regard to the circumstances of the case, which had excited a great deal of attention, and a good many of them had had to give their opinions, some on the one side and some on the other. But there was one aspect of the case which would commend itself to all, and that was that Dr. Goode had met with a very serious loss, and he might almost say that the result of the case had been such as to treat him with very extreme hardship—that he would be mulcted in something like an amount of £1,500. All were liable to make a mistake, and if every man who made such a mistake had to bear a loss of £1,500 for it, he was afraid that very few of them would be able to subscribe much to this fund. But what they had to do that night was simply to express their sympathy and condolence with a member of their profession who had suffered a very great misfortune, and to help him to bear his loss.

Dr. POWER moved—"That this meeting desire to convey its sincere sympathy and condolence to Dr. Goode for the unfortunate position in which he has been placed through the recent action in consequence of the performance of his duty."

Dr. BRADY moved—"That, in the opinion of this meeting, a circular be sent to each member of the profession in New South Wales in order to raise a subscription towards paying Dr. Goode's expenses."

Seconded by Dr. CHISHOLM, and agreed to.

Dr. PATERSON thought it would be well to consider the question of a medical defence fund, which would be much fairer to the profession generally.

The CHAIRMAN mentioned the fact that a movement was on foot to establish such a fund; but in the meantime it was not in operation, and what was proposed in the case of Dr. Goode was to do something at once.

Dr. POWER was then elected treasurer, and Dr. ELLIS secretary to the Dr. Goode Fund. A subscription list was opened in the room and a considerable amount subscribed.

SYDNEY UNIVERSITY MEDICAL SOCIETY.

THE last meeting for the Long Session was held in the Clinical Theatre, Prince Alfred Hospital, on the evening of Friday, August 12. The Hon. President occupied the chair. Although the state of the weather was very unfavourable for anyone to turn out there was a very good attendance. The general business having been transacted, Dr. Thomas Dixson read a paper on "The early history of the *Materia Medica*." The subject was dealt with at some considerable length, and proved very interesting. At the close of the paper Mr. Hinder proposed, and Mr. Purser seconded, a vote of thanks to Dr. Dixson. Other members who spoke on the subject were Professor Stuart, Mr. Holle, Mr. Dick, and Drs. Wilson and Graham.

It is gratifying to know that the meetings have been very well attended during the session, and the interest that has been displayed is not likely to fall off during the coming Short Session.

REVIEW.

ELEMENTS OF PHARMACOLOGY.

BY DR. OSWALD SCHMIEDERBERG, PROFESSOR OF PHARMACOLOGY, AND DIRECTOR OF THE PHARMACOLOGICAL INSTITUTE, UNIVERSITY OF STRASBURG. Translated, under the Author's supervision, by Thomas Dixson, M.B., Lecturer on *Materia Medica* in the University of Sydney. Edinburgh : Y. J. Pentland, 1887.

IT is a fashion rather prevalent now-a-days amongst many medical practitioners to affect a certain cynical scepticism in regard to the therapeutic value of drugs. In so far as this is the index of a reaction against the slipshod empiricism which has in times past usurped the title of therapeutics, it is well. This is a period of "destructive criticism," and there is every reason why Pharmacology should not be exempt from the tests of such a method. The manual under review presents important contributions to such a criticism.

But science has other work than the merely critical, and it is a mere confusion to mistake the shallow scepticism of the cynic for the scientific superiority of the skilled doubter which it apes. Is it not often the case that the assumption of the attitude of scientific doubt is only the cloak for indolent habits of observation which form the real obstacle to the progress of accurate knowledge, and have little or nothing in common with the impartial and judicial attitude of the sceptical, but not incredulous, experimentalist?

Students of Medicine (and we use the term in its wider and truer sense) who may prefer to do their reading in English owe a tribute of thanks to Dr. Dixson for enabling them to make the acquaintance, at first hand, of the ideas of so distinguished and laborious a worker in the field of Pharmacology as Professor Schmiedeberg. Commendation of the work itself at our hands is, of course, unnecessary. But we can conscientiously compliment Dr. Dixson on the excellence both of his choice of such a work and on the ability and care manifested in its translation. The introduction is an admirable and lucid statement of the general point of view of the science of Pharmacology (which term, by the way, is used with a more extensive significance than usual), and should be thoughtfully read by every one who wishes to appreciate the true aims and methods of modern Pharmacology and Therapeutics.

A number of instructive tracings, illustrative of pharmacological experiments carried on by the translator, have been introduced with considerable advantage, and in all its externals the book is a model of what such a book ought to be.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, SEPTEMBER 15, 1887.

EDITORIALS.

THE FIRST AUSTRALASIAN MEDICAL CONGRESS.

THE Australasian Medical Congress which has just concluded its sittings in Adelaide, is an event which marks a new epoch in the history of these colonies. The period chosen for its initiation could not well have been more appropriate, it being the centenary year of Australian settlement and the jubilee one of South Australia, at whose capital it was held. Its initiation was due in a great measure to the advocacy of Dr. B. Poulton, the Honorary Secretary, to whose devoted energy, in conjunction with the able and cordial assistance of his colleagues in Adelaide and its neighbourhood, its ultimate very marked success has been due. Numerous practitioners from the other Colonies were present, each, with the exception of Western Australia, being ably represented. The proceedings were commenced in the Town Hall on Tuesday, August 30, with the reading of the report of the Executive Committee by the Honorary Secretary, on the conclusion of which the Congress was declared open by His Excellency, Sir W. C. Robinson, G.C.M.G., Governor of South Australia (who in conjunction with the Governors of the other Colonies was a patron), in a kindly speech which cordially acknowledged the services rendered to society by the medical profession. On its conclusion the President (Dr. Verco) delivered the opening

address, which, being most admirable both in manner and substance, was received with vociferous plaudits. Each day's proceedings was opened at the University by an address from one of the Chairmen of Sections, delivered to the whole body; on its conclusion the four sections adjourned to their several apartments, when many admirable papers were read in each, useful discussions ensuing. The business terminated on Friday, September 2, and on that day it was decided that the next Congress should be held in Melbourne, under the Presidency of Mr. Fitzgerald, F.R.C.S., the date to be fixed by the Medical Societies of Victoria, at a period not later than the year 1890. It was felt that it would be a mistake for the Congress to meet too often, and that the practical result would probably be better, were a period of three years allowed for enquiry and research, and that an attempt to hold it annually might lead to work of a superficial character being presented for consideration, which would tend to lessen its value. The visitors were all delighted with their reception in the beautiful city of Adelaide, unquestionably the prettiest of Antipodean Capitals. The hospitality of its inhabitants was unbounded, and in the generous kindness of his professional *confrères*, each stranger truly realized the "brotherhood of medicine." In addition to the undeviating cordiality and constant attention of the doctors, the members of the Congress were feted by His Excellency the Governor, the Chief Justice, the Mayor, Mr. Barr Smith, Sir Thomas Elder and other magnates, who vied with each other in showing courteous appreciation of the value of the labours of the members.

PROSECUTION OF QUACKS IN QUEENSLAND.

AMONGST the appendices attached to the report of the Select Committee on the Practice of Medicine and Surgery in N. S. Wales, is the advertisement, from the *Goulburn Herald*, of the gang who style themselves the "Doctors of the great English Staff of Specialists, president, W. Ainslie, M.D.", (with eighteen other letters). This delectable crowd had extended their operations to Queensland, but in that colony there is a law which renders conduct, which in New South Wales can be carried on with perfect impunity, a dangerous proceeding. The matter has been brought before the

Medical Board in Brisbane, and steps have been taken for their suppression. At the Rockhampton Police Court, on June 29th, a man named Edmund Franck, who, if not one of the same lot, is evidently of similar character, was prosecuted by direction of the Queensland Medical Board for practising as a medical practitioner without being registered in Queensland. He was convicted and fined £20—the highest penalty. The police magistrate, Mr. Lukin, in passing sentence said, "he had sent many a man to gaol for a less dishonest proceeding, and that the parties who had instituted the proceedings deserved the thanks of the community." The case was proved principally on the evidence of two witnesses, one of whom was Henry Thrussel, who went to consult him. The witness stated that Franck made no examination, but told him his liver was out of order and that he would give him something to cure him for £2 10s., which demand he subsequently lowered, on the protest of the witness, to 10s. 6d. A Mrs. Budden testified that she went to consult Franck on July 20. She told him "her breathing was very bad, and she thought she was suffering from heart disease." He said, "she was not suffering from heart disease, but from liver complaint." He never examined her. He gave her medicine, and she paid him two guineas. Mr. Lyons, the lawyer who appeared for the defendant, admitted the case was proved, but stated he had allowed it to be gone on with so that the evidence might be heard. He contended that the highest penalty should not be inflicted on his client, who was a foreigner, and who, he understood, was really an M.D. of Paris, and a Bachelor of Science. His client had not sold anything to hurt anyone, as the medicine consisted only of aloes and tincture of iron. Many men earned their living like the defendant, and it was only he was unfortunate in being caught.

The attorney was justifiably cautious in this statement, for he only said that he *understood* his client was an M.D. of Paris and a Bachelor of Science, and he in no way made himself responsible for the truth of this assertion. We think it is evident that a man who prescribes for patients without examining them, and who apparently lumps all cases under the general head of "liver complaint," is hardly likely to possess such distinguished qualifications. From the same statement it appears he uses but one remedy—a combination of iron and aloes—the chief virtue of which consists in the fact that it would "not harm anyone." As has been shown by the recent Select Committee a worse state of things exists every day in New South Wales, but, unlike Queensland, there is no remedy, and stupid people may be swindled like this with impunity.

PROSECUTION OF UNREGISTERED PRACTITIONERS IN SYDNEY.

DURING the last few weeks three unregistered medical practitioners have been committed for trial in Sydney, one on a charge of murder, the others for manslaughter. In the first case the Attorney-General declined to file a bill, the others were arraigned, one being acquitted, and the other, John Samuel Pitt, being convicted and sentenced to nine months imprisonment. Though possessing no qualification which entitled them to be registered by the Medical Board, they designated themselves "Dr," placing it on their doors and in their advertisements. Public attention has been aroused by the revelations in the recently published report of the select committee, and it appears probable that some legislative action will be taken which may result in such men being prevented from representing themselves as properly educated and qualified practitioners, and so deceiving the ignorant public, thus virtually obtaining their money under false pretences.

PACKING FEVER PATIENTS.

We have to thank a gentleman, who wrote in the *Sydney Morning Herald*, on August 16, on this subject, under the signature of "Physician," for his able letter. It was apparently written to expose the fallacy and absurdity of the statements put forward by an inspired genius named Robert Bone, who not content with preaching oracularly on the advantages of packing in fever cases, must, as is usual with such people, attempt to strengthen his assertions by gratuitously accusing the medical profession of ignorance and prejudice with regard to this line of treatment. It is astonishing on what slight acquaintance with one or two instances an ignorant layman is quite prepared to instruct medical men in the treatment of disease. We think that we cannot better sum up our estimate of the divinely-gifted Mr. Bone than by quoting, from "Physician's" letter, the following passage:—"I do not feel it necessary to attempt to vindicate the honour of the profession, or to defend it from such insinuations as appear in the letter of your correspondent, Mr. Robert Bone. It will be kinder to assume that his acquaintance with medical men must be as slight as his knowledge of medical treatment, which latter seems very hazy, judging from his remarks re brandy, starvation, and purgatives in typhoid fever."

MEDICAL FEES.

A CASE of interest to medical men was tried in the Bathurst Small Debts Court on September 5, when Dr. Finlay sued Thomas Collier for £6 16s., fees and mileage to Kelso, including two visits at two guineas each at 8 and 6 a.m. The defendant paid £3 5s. into court, and produced a bill from a Dr. Bassett to show that he paid nine visits, supplied medicine and performed an operation for £3 7s. 6d. The Bench gave a verdict for 19s. in addition to the amount paid into court, and 10s. 6d. for Dr. Finlay's expenses, virtually four guineas, thus disallowing the fee of two guineas for night attendance. Dr. Finlay's charges were based on the scale of fees published in Bruck's "Australasian Medical Directory and Handbook." We think the decision of the magistrates who tried this case most unjustifiable, and believe that they could have bestowed but little thought on the matter when they gave it. To say that a medical man is not entitled to a larger fee when called from his bed, than if the work were done during the day is worthy of the mental capacity of the typical bush J.P., whilst the admission of the account of another practitioner for a former attendance as evidence, was, in our opinion, a most extraordinary action. Our advice to medical men in districts blessed with courts like this, is to bring all actions before a District Court Judge.

THE following letter, which appeared in the *Archives of Dentistry* for May, 1887 (vol. iv. No. 5, p. 217), published in St. Louis, U.S.A., will, doubtless, be of interest to our readers :—

AMERICAN DENTISTRY IN THE ANTIPODES.

St. Louis, Mo., April 9, 1887.

EDITOR ARCHIVES.—A short sketch of what has been done, and the grit shown by American dentists in Sydney, Australia, may not be unintresting to some of your readers.

About four years ago a sum equal to \$1,000,000 (one million dollars) was left by Mr. J. H. Fairfax to found a Technical College, provided the Government gave a similar amount; the amount was given and the college built. Dr. Slate and Dr. Symes, D.D.S.'s of this country, thought that a good opportunity had arrived to open a school of Mechanical Dentistry, a school of Dental Surgery having already been established at the Sydney University through the medium of these gentlemen.

Striking while the iron was hot, Dr. Slate had the pleasure of knowing that his proposals met with approbation, and the class was established, and now some twenty-five or thirty young men are being taught mechanical dentistry as well as the usual curriculum of University studies necessary to qualify them for the degree of D.D.S.

Dr. Slate and Dr. Symes are not by any means the only ones who have advanced American dentistry in the antipodes. Dr. Lovell, Dr. O'Neill and Dr. Leonard of Melbourne, Dr. Hubert Norman, of Adelaide, South Australia, have one and all shown by their energy and push that dentistry in this country means something,

more than merely drawing a tooth. They have shown that in the majority of cases a decayed tooth does not mean that it is lost for ever, but by the process of filling, teeth which a few years ago would have been ruthlessly torn from their beds, as of no further use, are now made "as good as gold" can make them.

Yours,

F. K. LAMBERT, D.D.S.

HAVING made enquiries of the Board of Technical Education of N.S.W. as to the truth of the statements contained in the above letter, we received the following communication from the President, E. Combes, Esq., C.M.G., Chevalier of the Legion of Honour :—

87,687.

Offices of the Board, 129 Phillip Street,
Sydney, 23rd August, 1887.

Sir,—In reply to your letter of to-day's date, asking for information as to the truth of the statements made by F. K. Lambert in the *Archives of Dentistry* for May last, I have to inform you that no legacy whatever from Mr. Fairfax, or anyone else, has ever been bequeathed to the Sydney Technical College.

Neither Dr. Slate nor Dr. Symes has ever been in correspondence with the Board of Technical Education. As to the implied connection of Drs. Slate and Symes with the Sydney Technical College, the statement contained in F. K. Lambert's letter is absolutely false.

We have a class of mechanical dentistry attended by twelve students, taught by Mr. H. G. Low, but with this neither Drs. Slate nor Symes has any relations whatever.

I am, yours obediently,

EDWARD COMBES,

President.

The Honourable J. M. Croed, M.L.C.

[We think no comment is necessary when we publish the foregoing letter, which we commend to the notice of the Editor of the *Archives*. We may add that both Dr. Syme and Dr. Slate disclaim all knowledge of F. K. Lambert's letter, and that the information as to the Melbourne individuals is equally inaccurate.—ED. A.M.G.]

A CORRECTION.

In the beginning of July, a telegram appeared in the Sydney daily papers and in the Melbourne *Argus*, stating that Dr. Hallowes, while on a visit at Bourke, died suddenly through the bursting of a blood-vessel; this report found its way into the August number of the *A.M.G.*, and we are now pleased to inform our readers that this report is not correct, as we have received a communication from Dr. H. C. Hallowes, of St. John-street, Launceston, Tasmania, who is the only practitioner of that name throughout the colonies, informing us that he is still alive, and practising at Launceston as heretofore. We regret that such a mistake should have occurred, and we hope Dr. Hallowes may continue to practise his profession for many years to come.

THE MONTH.

NEW SOUTH WALES.

AT the monthly meeting of the Board of Directors of the Prince Alfred Hospital, Sydney, a letter was received from the registrar of the University, covering a resolution adopted by the senate with reference to the appointment of a tutor in medicine; the proposal of the senate was acceded to. The following resolution was also adopted on the motion of Sir Alfred Robert's:—"That, as some of the senior students will probably become legally qualified medical practitioners at the end of this year, an additional Resident Medical Officer be then appointed, and the post of Junior Officer be filled by one of their number; that the election take place by competitive examination; that such election be for one year only; and that the salary be at the rate of (blank) per annum, with board and residence."

THE Premier has received a report from Mr. Johnson, S.M., who was appointed some time since to inquire into the dispute between Miss Holden, the Lady Superintendent of the Children's Hospital at Glebe Point, and the Committee of that Institution. The inquiry shows that the complaints made by Miss Holden against two members of the Medical Staff had not been substantiated, and that the course taken by the Board in dismissing Miss Holden was the only one open to them. The report also recommends the appointment of a paid Medical Officer, who would visit the hospital at stated hours each day.

FOUR cases of small-pox have occurred on board the Chinese Steamer "Tsinan," which arrived in Port Jackson on August 19.

THE following medical practitioners have been appointed to the Commission of the Peace in New South Wales, viz.:—Drs. G. P. Baldwin, A. S. Bowman, W. H. Cutts, W. W. Elmslie, A. E. Fitzpatrick, E. Godson, A. Houison, J. Lamrock, H. W. Mason, B. J. Newmarch, F. H. Quaife, A. Renwick, C. Rooke, A. Ross and E. Sinclair.

DR. WOODWARD, Honorary Surgeon of the Sydney Hospital, has written to the Board of Directors of this Institution suggesting that parchment certificates of character and qualifications should be issued to those of the nurses who passed the necessary examinations after two years' service. Dr. Woodward stated his willingness to instruct the nurses in elementary anatomy, physiology and surgery. Both proposals were agreed to by the Board.

AT a meeting held in Sydney, on August 16, and presided over by the Honorable J. M. Creed, M.L.C., a motion was passed "That it is desirable that a society be formed for the purpose of carrying out cremation in New South Wales." A provisional committee, consisting of the Hon. Dr. Creed, Dr. MacLaurin, the Rev. E. R. Grant, Dr. Roth and Mr. Wade, to draw up rules for the guidance of the society, was appointed.

A WOMAN named Mary Gilt died at the Sydney Hospital, on August 22, while under the influence of chloroform, administered by Dr. Fisher, the Resident Medical Officer of the institution. At the subsequent inquest the jury found that the deceased died from the effects of chloroform, which was administered with due care and caution. They added that hospital patients should always be examined by two medical men before being placed under the influence of chloroform.

A MAGISTERIAL inquiry was held at Goulburn, on August 25, on the body of John D. Rhodes, who died

under chloroform at the Goulburn Hospital whilst an operation was being performed on his right thumb. After hearing the evidence the police magistrate found that the deceased met with his death by the inhalation of chloroform duly and carefully administered by two legally-qualified medical practitioners for the purpose of performing a surgical operation.

WE deeply regret to have to record the death of Dr. August Dückershoff (better known as Dr. Hoff), who died at his residence, 197 Liverpool-street, Sydney, on August 28, after a somewhat protracted illness. For several weeks previous he had been confined to his room in the last stage of consumption. Dr. Dückershoff was 44 years of age, unmarried, and was a native of Westphalia, Germany. Six years ago he came to the colony for the benefit of his health, and soon gained the esteem of other members of his profession. The deceased gentleman was a M.D. of the University of Leipzig, and a Physician and Surgeon by State's examination. He devoted himself to the treatment of diseases of the skin and larynx, and was the only pure specialist for such diseases throughout the Australian Colonies. The profession in Australia has sustained, by his death, a severe loss, and many of its members have lost a sincere friend.

HENRY WESTENRA LENTAIGNE, L.R.C.S.I. 1878, L. et L. Mid. K.Q.C.P. Irel. 1880, of Hunter's Hill, near Sydney, was found dead at his residence on Saturday evening, August 13, under circumstances pointing to suicide by shooting. An inquest was held on his body by the district coroner, when the jury found "that the said Henry Westenra Lentaigne died from the effects of a pistol-shot wound in his head inflicted by himself, but whether intentionally or accidentally the evidence does not enable us to decide." The deceased gentleman was only 29 years of age.

DR. J. MARTIN BROWNE has commenced practice at 67 Pyrmont Bridge-road, Glebe, a suburb adjoining Sydney.

DR. T. M. HARDING has succeeded to the practice of Dr. Jaa Bruce, at Richmond.

DR. E. R. KAVANAGH has commenced practice at Junee, 287 miles S. of Sydney.

DR. B. KORFF, late of Broken Hill, has removed to Jerilderie, on the Billabong Creek, in a pastoral and agricultural district, 416 miles S.W. of Sydney.

DR. C. A. PATRICK, a new arrival, has started practice at Crystal-street, Petersham, a suburb of Sydney.

DR. H. A. L. POPP has settled at Corowa, on the Murray River, in a fine pastoral and vine-growing district, 422 miles S.W. of Sydney.

DR. R. A. SIMPSON, late surgeon in the Royal Navy, has commenced practice at "Alva," Norton-street, Leichhardt, a suburb adjoining Sydney.

DR. J. C. SOUTER, late of Emmaville, has removed to Bingera, on the Gwydir River, in a district abounding in diamonds, gold and copper, 352 miles N.W. of Sydney.

DR. P. THORNTON, late Medical Officer of the Wentworth Hospital, who has been elected Medical Superintendent of the Ipswich Hospital (Qu.), has been presented by the residents of the Wentworth District with a testimonial consisting of a purse of sovereigns and an address expressing the sincere regret generally felt at his departure.

NEW ZEALAND.

JOHN MACKENZIE GORDON, M.B. et Ch. M. Edin. 1866, formerly of Hay (N.S.W.), and late of Melbourne, died from rupture of a blood-vessel, at Rangiora, in July last.

DR. F. G. M. BRITTIN, late of Christchurch, has removed to Ross, a gold-mining township near the coast, 20 miles S. of Hokitika.

DR. R. HOADLEY, late of Wakefield (Nelson), has removed to Hororata, 43 miles W. of Christchurch.

QUEENSLAND.

NOT less than 51 candidates have applied for the vacant position of Resident Medical Superintendent of the Rockhampton Hospital.

ALEXANDER MACKINTOSH, M.B. et Ch. M. Glas. 1874, late of Sunny Corner (N.S.W.), and formerly for four years Resident Medical Officer at the Ipswich Hospital, died at Croydon in July last.

DAVID WATKINS O'CONNOR, L.R.C.P. et R.C.S. Edin., 1871, died at Maryborough last month. The deceased gentleman was Government Health and Medical Officer at Maryborough, and a Surgeon in the Queensland Marine Defence Force. He was formerly a Surgeon in the Royal Navy.

THOMAS RIDGLEY, M.B. et Ch. M. Edin. 1881, who practised at Townsville for the last four years, is dead.

DR. M. MAGILL has commenced practice at Thargomindah, on the Bulloo River, in a grazing district, 670 miles W. of Brisbane.

DR. K. I. O'DOHERTY, late of Sydney, and formerly of Brisbane, has settled at Croydon, the centre of a gold-fields district, in Northern Queensland.

DR. G. A. VAN SOMEREN has been appointed Official Visitor to the Reception House in Townsville.

VICTORIA.

THE Inspector of Lunatic Asylums states in his annual report that the total number of registered insane in the colony at the close of 1886 was 3,380, or 3·27 to every 1,000 of the population, against 3·25 in the previous year. Of the 669 received during the year, only 164 were accompanied by their relatives or friends, 362 were taken to the asylums by the police, and the remainder were from the gaols, benevolent asylums, and other public institutions. The total expenditure of the asylums for the year was £101,504, the cost of maintenance being at the rate of 10s. 0½d. per head, or 4½d. less than last year. The asylums are at present over-crowded, and additional accommodation for 250 men and 250 women is urgently required.

THE Central Board of Health has received a communication from the Education Department asking how far it was desirable to close country schools when a comparatively mild attack of measles or whooping cough occurred among the children. The Board decided that where the attendance fell very low the school might be closed for a fortnight; otherwise, unless the disease assumed a very virulent form, there was no need to close a school on account of an attack of measles or whooping cough. In cases where scarlatina, diphtheria, or typhoid fever broke out the schools ought to be closed and thoroughly disinfected.

THE Committee of the Melbourne Hospital, in reply to a question which had arisen as to whether a gentleman holding a degree from the Brussels University was

qualified to serve the Institution, received a letter from the registrar of the Melbourne University stating that the Brussels University was not one of the foreign institutions recognised by it.

AT a meeting of the Committee of the Alfred Hospital, on August 5, a letter was received from Dr. O'Hara suggesting the starting of a school of surgery at the Alfred Hospital for fifth year medical students. He asked for the views of the Managers on the matter. Upon discussion the following resolution was carried, on the motion of Mr. Thomson:—"That the Managers think that the time has now arrived when a clinical school should be established in connection with the hospital, and request the Hon. Medical Staff to submit a report thereon for the consideration of the Managers." At the same meeting a report from a Sub-Committee, signed by Dr. Adam and Dr. Rudall, and confirmed by the chairman of the Hon. Medical Staff (Dr. Embeling), recommended that a department for the special treatment of diseases peculiar to women should be instituted in the hospital for both in and out patients. It was resolved to defer the consideration of the report for four weeks.

A MEETING of the Hon. Medical Staff of the Alfred Hospital, Melbourne, was held on Monday, August 15, Dr. Embeling in the chair. It was resolved that a Sub-Committee be appointed to consider the question of establishing a clinical school in connection with the Hospital.

PERMISSION has been granted by the Managers of the Alfred Hospital, Melbourne, to Dr. O'Hara to give instruction to medical students in operative surgery at the Institution, it being taken for granted that the lectures would not interfere with the general work of the hospital.

DURING the twelve months ending June 30, 2,481 cases received treatment at the Melbourne Women's Hospital, of which 961 were indoor patients. There were also 35 cases assisted at their own homes, and 125 women who were without homes were boarded out, owing to the want of accommodation at the Institution. The average cost per head for the maintenance of inpatients had been £4 11s. 2d.

THE number of indoor patients admitted during the twelve months ending June 30 into the Melbourne Hospital for Sick Children was 501; in the house June 30, 1886, 48; total for year, 544. Number cured, 395; improved and admitted as out-patients, 100; died, 37; remaining, June 30, 1887, 12. Outdoor patients—New cases, 5,113; total attendances, 17,163; number treated by galvanism, 646; number of casualties, 1,115.

THE Central Board's Inspector of Markets, Meat, Abattoirs, and Dairies inspected during the last year 7 public abattoirs (of which 2 were in an indifferent, and 3 in an offensive condition); 46 private slaughter-houses (25 of which are classed as offensive, and 4 as indifferent); 238 butchers' shops, yards, markets, &c. (of which 195 were in good and clean condition, 16 indifferent, and 27 offensive); and 38 dairies (of which 18 were clean, 10 indifferent, and 10 offensive).

AT a meeting of the University Council, on September 5, Dr. Williams and Dr. Moloney were re-elected as Clinical Lecturers in Medicine, and Mr. Fitzgerald as Clinical Lecturer in Surgery. As Mr. Girdlestone had not been re-elected Surgeon to the Melbourne Hospital, the question of the appointment of the second Clinical Lecturer in Surgery was remitted to the medical faculty.

A MEETING of the Medical Society of Victoria was held on August 10, at their hall, Albert-street, Mel-

bourne, to consider the complaint made by Dr. Springthorpe against the action of the Committee of the society in sending to the Royal College of Physicians, London, a copy of the circular which he had issued to the governors and subscribers of the Melbourne Hospital in furtherance of his candidature for the position of Honorary Physician of the hospital, it being regarded as having made a breach of medical etiquette. Dr. Springthorpe made a long statement in support of his complaint, in which he attacked the Committee for the action they had adopted respecting the circular. It was then proposed by Dr. Harricks, and seconded by Dr. Cox, that the Committee had acted in an arbitrary way in dealing with Dr. Springthorpe's circular. An amendment was moved by Dr. C. Johnston endorsing the action which the Committee had taken. The amendment was seconded by Dr. Hinchcliff, of Sandhurst, and was carried by about 50 votes to 14. The meeting then closed.

DRS. C. BAGE, G. Annand, D. Grant, C. E. Gray, and J. de B. Griffith have been declared duly elected Honorary Physicians attending the out-patients of the Melbourne Hospital, without ballot, as there were just sufficient nominations for the positions.

THE election of Medical Officers to the Melbourne Hospital took place in the Athenaeum on August 18th and created considerable interest. The following were elected:—Physicians for in-patients: Drs. Moloney, J. Williams, Springthorpe, and MacInerney. Surgeons to in-patients: Drs. Fitzgerald, Beaney, C. S. Ryan, and James. Surgeons to out-patients: Drs. F. D. Bird, J. P. Ryan, Webb, Moore, and Syme. The unsuccessful candidates were—Drs. Lefevre, E. Valentine Browne, Jaa. Jamieson, Fulton, Kennison, Stirling, and Brett.

SAMUEL ORMSBY HIGGINS, M.B. et Ch. B. Melb., 1881, formerly Medical Officer of the Tenterfield (N.S.W.) and Melbourne Hospitals, and late of Geelong, died at "Kilenna," Malvern, near Melbourne, on August 19, at the age of 29 years.

WILLIAM JONES, M.R.C.S. Eng., 1886; L.S.A. Lond., 1885, late of Merino, died at Belfast (Port Fairy), on September 1, aged 70 years.

DR. C. FETHERSTONHAUGH has settled at Colac, in the Western district, 96 miles S.W. of Melbourne.

DR. A. H. GORDON, of Cheltenham, has been elected Resident Surgeon at the Clunes Hospital. There were 15 applicants for the vacant position.

DR. F. J. KEYES has commenced practice at Nathalia, on the Broken Creek, in an agricultural district, 139 miles N. of Melbourne.

MEDICAL APPOINTMENTS.

Bowe, Arthur, M.R.C.S.E., L.R.C.P. Edin., to be Health Officer for shire of Ararat, Vic.
Brittin, Frederick George Morris, M.R.C.S.E., to be a Public Vaccinator for the district of Ross, N.Z.
Christie, William Ledingham, M.B., to be Honorary Surgeon of the West Taleri Rifle Volunteers, N.Z.
Clark, Henry Bolton, M.R.C.S.E., to be Public Vaccinator at Heathcote, Vic., vice Dr. C. Robinson, who has left the district.
Cohen, Aaron Algernon, M.D. Aberd., M.R.C.S.E., to be Honorary Surgeon of the Grafton Reserve Corps of Volunteer Light Horse, N.S.W.
Cutts, jun., William Henry, M.B. et Ch. B. Melb., to be Public Vaccinator for West Melbourne, Vic.
Fleetwood, Thomas Falkner, M.B. Dub., F.R.C.S.I., to be Health Officer for the Port of Warrnambool, Vic.
Hacon, Walter Edward, L.R.C.P. Lond., M.R.C.S.E., to be Public Vaccinator for the District of Christchurch, N.Z.
Harricks, John Hugh, M.R.C.S.E., L.K.Q.C.P. Irel., to be Government Health and Medical Officer at Maryborough, Qu.

Hassell, Gray, M.B. et Ch. M. Aberd., to be an additional Public Vaccinator for the Wellington District, N.Z.
Hinchcliff, Edwin, M.D., M.R.C.S.E., to be Health Officer for shire of Strathfieldsaye, Vic., vice J. D. Boyd, M.D., resigned.
Hoadley, Robert, M.D., M.R.C.S.E., to be Public Vaccinator for the district of Hororata, N.Z.
Jeffreys, James Graham, L.S.A. Lond., to be Assistant Medical Officer at the Seaford Lunatic Asylum, near Dunedin, N.Z.
Kilpatrick, William, M.B. Melb., to be Health Officer for shire of Eltham, E.R., Vic.
Korff, Berthold, M.D. et Ch. D. Wirsb., to be Government Medical Officer and Vaccinator for the district of Jerilderie, N.S.W.
Lewis, George Alfred, M.B. Dub., L.R.C.S. Irel., to be Honorary Surgeon of N. Battery, N.Z. Artillery Volunteers.
MacKenzie, John Hugh, L.R.C.S. Edin., to be Public Vaccinator for Tallangatta, Vic.
Nichol, Henry, M.R.C.S.E., L.R.C.P. Edin., to be Public Vaccinator for Bendigo, Vic.
O'Doherty, Kevin Ixod, F.R.C.S.I., L.K.Q.C.P. Irel., to be Government Medical Officer at Croydon, Qu.
Pollen, Henry, M.B. et Ch. M. Dub., L.K.Q.C.P. Irel., to be Honorary Surgeon of the East Coast Hussars, Cavalry Volunteers, N.Z.
Ross, William Chisholm, M.B. et Ch. M. Melb., to be Health Officer for the Warracknabeal District, Vic., vice W. J. Carroll, L.R.C.S., resigned.
Souter, John Clement, M.D. et Ch. M. Aberd., to be Government Medical Officer and Vaccinator for the District of Bingera, N.S.W.
Taffie, Oliver Granville, L.R.C.P. et R.C.S. Edin., to be Health Officer for shire of Huntley, Vic., vice Jas. Boyd, M.D., resigned.
Thornton, Philip, M.R.C.S.E., M.R.C.P. Edin., L.S.A. Lond., appointed Medical Superintendent of the Ipswich Hospital, Qu.
Wickens, George Frederic, M.B. et Ch. M. Glas., to be Public Vaccinator for Romsey and Lancefield, Vic.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

M'Nish, James, M.B. Glas., 1883; L.R.C.P. Edin., 1886; M.S. Glas. 1883; L.R.C.S. Edin. 1886.
Simpson, Robert Arthur, M.B. et M.S. Glas., 1874.
Merrifield, Sydney Sargent, M.R.C.S. Eng., 1883; L.S.A. Lond., 1883.
Kavanagh, Edmund Raphael, L.R.C.P. Edin., 1887; L.F.P.S. Glas., 1887; L.R.C.S. Edin., 1887.
Brownrigg, Harbert Watson, L.R.C.S. Irel., 1879; L. et L. Mid. K.Q.C.P. Irel., 1881.
Butler, Michael Lyons, L.R.C.P. Edin., 1886.
Harwood, Alfred John, L.R.C.P. Edin., 1886; L.F.P.S. Glas., 1886; L.R.C.S. Edin., 1886.
Baines, William L'Estrange, M.B. et B. Ch. Dub., 1886.

For additional registration:—

Woods, William Cleaver, M.D. Edin., 1886.

QUEENSLAND.

Bellamy, Charles Penrose, L. et L. Mid. R.C.P. Edin., 1874; M.R.C.S. Eng., 1874.
Johnstone, William Henry, L. Med. et Surg. Dubl., 1874.
Humphrey, Ernest, M.R.C.S.E.
Kealy, Joseph Patrick, L.R.C.S. Irel. et L.K.Q.C.P. Irel., 1880.
Willis, George Owen.

TASMANIA.

Gormley, John William, L.R.C.S.I., 1882; L. et L. Mid. K.Q.C.P. Irel., 1883.

VICTORIA.

Phelps, William, M.R.C.S. Eng., 1876; L.S.A. Lond., 1875.
Pope, Henry Alexander Lepraria, M.R.C.S. Eng., 1886; L.S.A. Lond., 1886.
Keyes, Francis Joseph, M.D. et Ch. M. R. Univ. Irel., 1885.
Fetherstonhaugh, Charles, M.B. 1875, Ch. M. 1876, Dub.; L. et L. Mid. R.C.S. Irel. 1876.

Additional qualifications registered:—

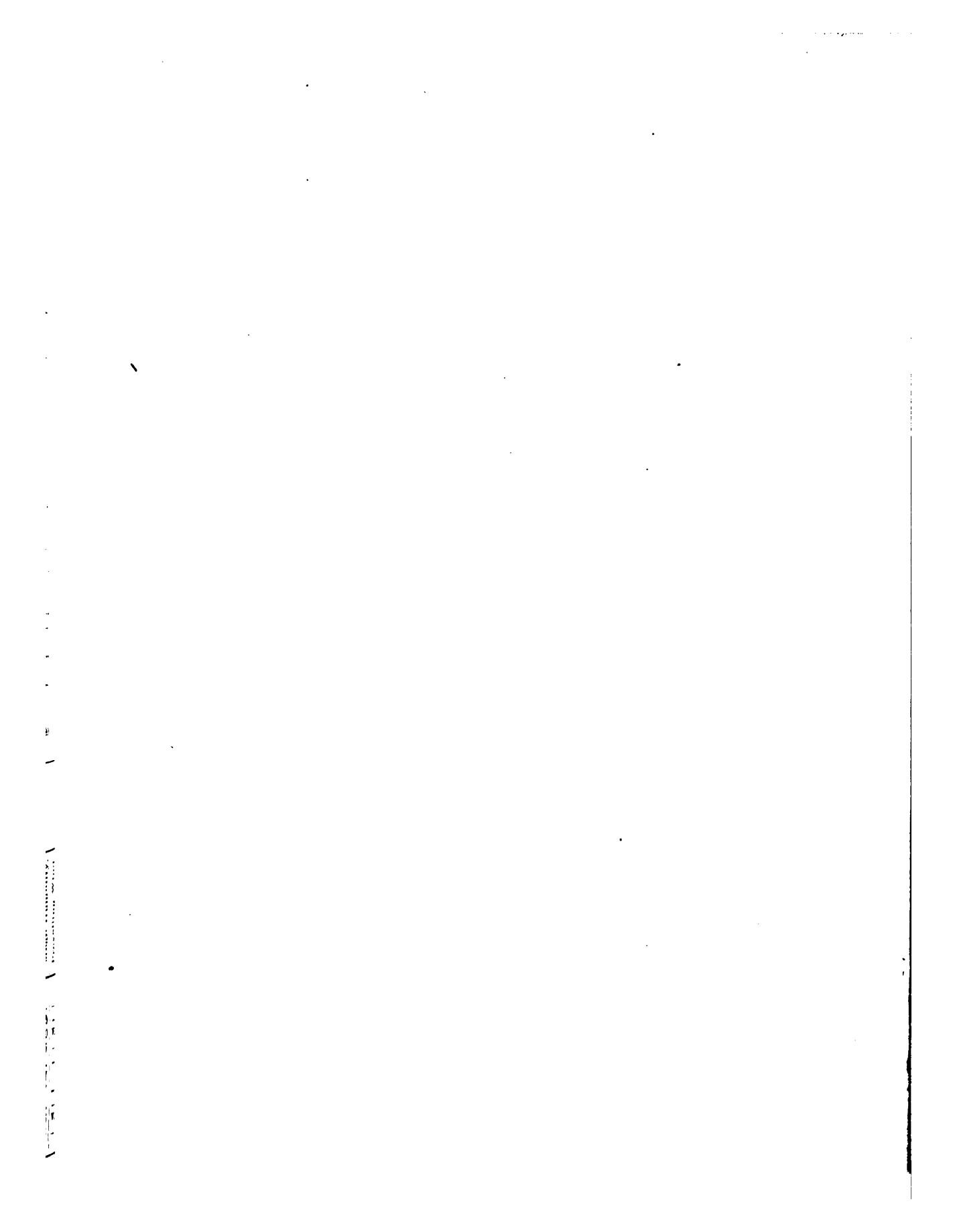
Bird, Frederic D., Ch. B. 1884, Ch. M. 1886, Melb.
Syme, George A., F.R.C.S. Eng. 1886.

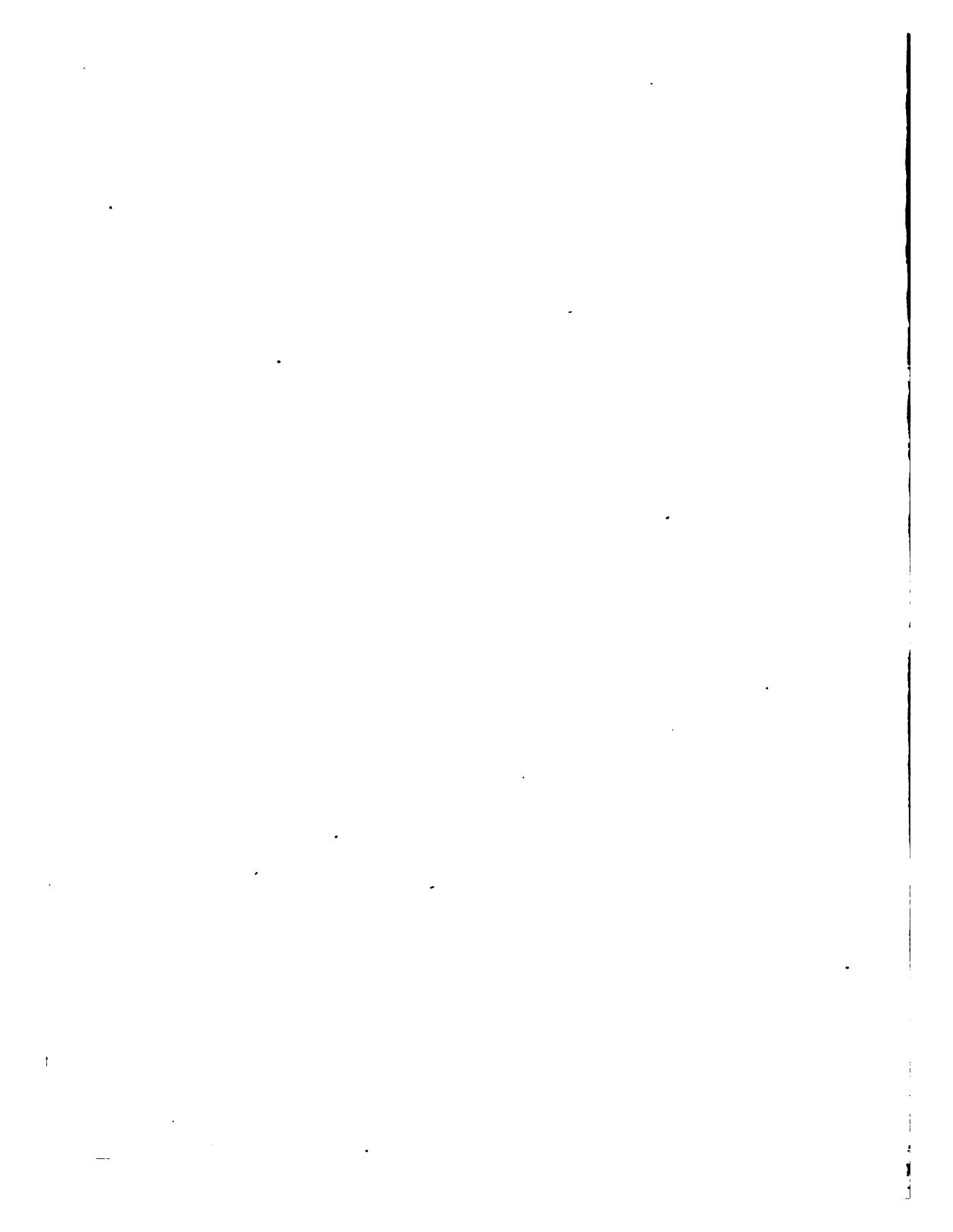
REPORTED MORTALITY FOR THE MONTH OF JULY, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Measles.	Number of Deaths from								
						Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	805	130	30	...	2	2	1	2	3	19	16	12	2
Suburbs	200,000	880	215	86	...	..	6	2	5	28	18	12	12	14
NEW ZEALAND.														
Auckland	35,965	101	26	12	...	1	...	...	1	2	1	1	1	3
Christchurch	15,684	38	18	7	...	..	5	1	..	2	2	1	1	1
Dunedin	24,283	62	21	5	...	1	1	...	...	2	1	1	1	1
Wellington	26,956	68	31	11	...	1	1	...	...	4	4	1	1	5
QUEENSLAND.														
Brisbane	82,571	134	87	19	{	...	11	1	3	5	9	10	2	7
Suburbs	41,082	227	59	13	...	...	...	...	1	2	11	3	1	1
SOUTH AUSTRALIA.	808,836	982	276	99	...	...	12	3	5	4	25	17	19	17
Adelaide	42,904	120	62	13	...	...	...	...	1	2	11	3	1	6
TASMANIA.														
Hobart	31,068	82	29	10	...	...	1	...	3	...	9	5	...	4
Launceston	19,449	77	31	9	...	...	1	...	6	...	3	3	...	2
Hospitals, Asylums, Gaols, &c. .	1,810	...	41	...	...	...	...	...	...	...	...	...	...	...
Country Districts.....	88,904	244	82	...	...	...	2	1	1	1	...	...	...	...
VICTORIA.														
Melbourne	69,774	134	86	{ 167	2	1	17	8	15	9	76	42	40	39
Suburbs	275,606	1,058	477	...	...	...	...	...	...	...	...	...	...	...

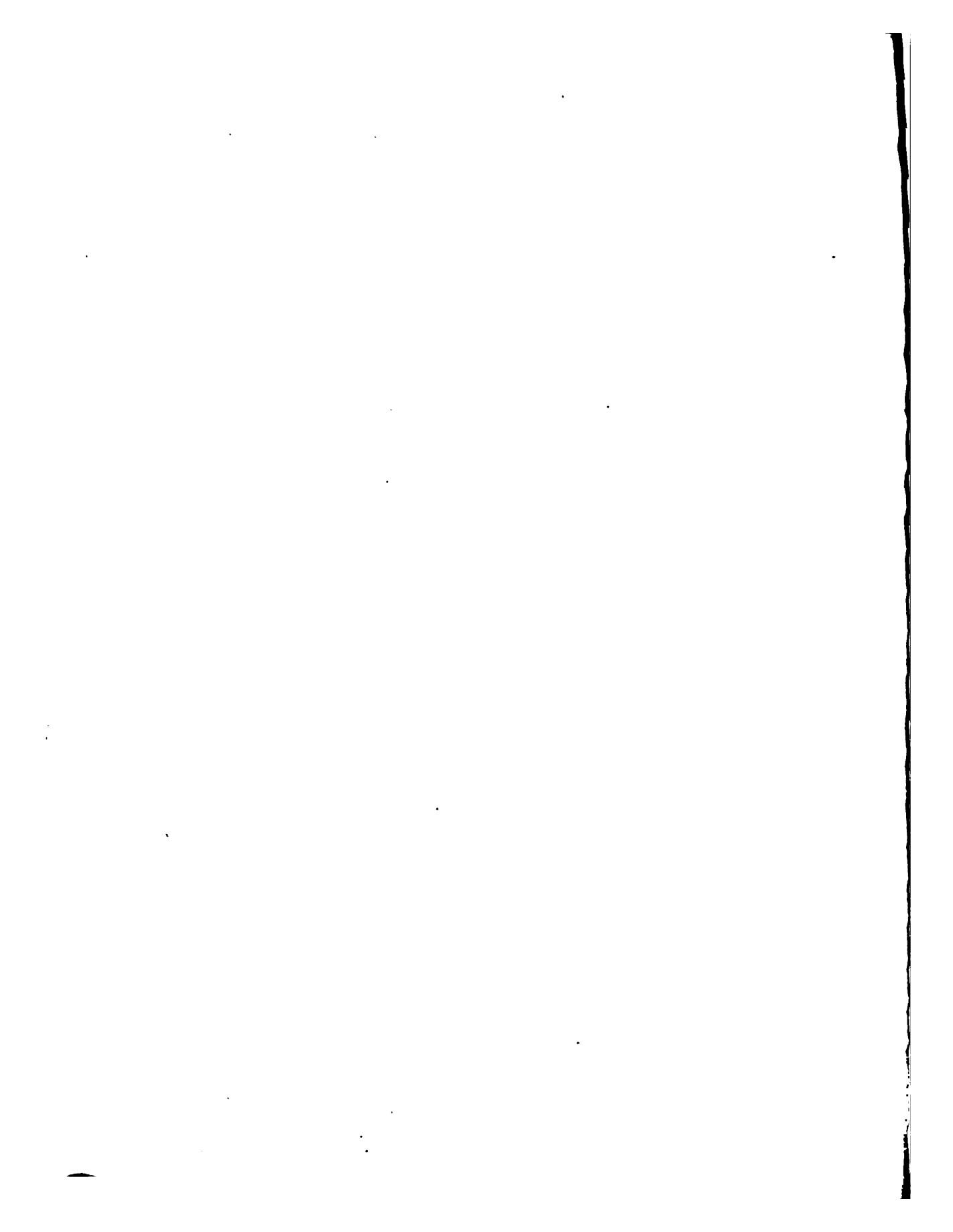
METEOROLOGICAL OBSERVATIONS FOR JULY, 1887.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.	Inches		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Mean Shade.			Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	61·5	51·8	36·5	29·966	...	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	123·	63·	51·9	35·3	...	5·92	24	79	...	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	129·9	77·	57·5	40·4	30·118	7·507	8	70	W.	...	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	108·	57·4	42·8	30·2	...	5·021	13	85	...	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E. ....	...	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.	58·2	46·6	33·	29·791	3·65	23	87	...	...	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.	57·5	45·6	27·	29·862	6·21	19	77	...	...	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.	59·9	49·6	34·9	29·918	2·68	17	76	...	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.	72·7	53·9	40·6	30·057	3·64	10	76	W.	...	...	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	111·	59·	47·7	36·	...	5·497	16	86	...	...	...









NO 785